

2007 Evidence of Coverage

Tufts Health Plan
Medicare Preferred
Group Retiree
HMO Prime



*This booklet gives the details about
your Medicare health coverage and
explains how to get the care you need.
This booklet is an important legal
document. Please keep it in a safe
place.*

January 1 – December 31, 2007

18-HMOG-2007-2/07

TUFTS  Health Plan
 Medicare Preferred

Welcome to Tufts Health Plan Medicare Preferred HMO Prime

Welcome to Tufts Medicare Preferred HMO Prime!

We are pleased that you've chosen Tufts Medicare Preferred HMO Prime.

Tufts Medicare Preferred HMO Prime is a **H**ealth **M**aintenance **O**rganization "HMO" for people with Medicare.

Now that you are enrolled in Tufts Medicare Preferred HMO Prime, you are getting your care through Tufts Associated Health Maintenance Organization, Inc. (Tufts Health Plan). Tufts Medicare Preferred HMO Prime, an HMO, is offered by Tufts Health Plan. (Tufts Medicare Preferred HMO Prime **is not a "Medigap" or supplemental Medicare insurance policy.**)

This booklet explains how to get your Medicare services through Tufts Medicare Preferred HMO Prime.

This booklet, together with your enrollment form and any amendments that we may send to you, is our contract with you. It explains your rights, benefits, and responsibilities as a member of Tufts Medicare Preferred HMO Prime. It also explains our responsibilities to you. The information in this booklet is in effect for the time period from January 1, 2007, through December 31, 2007.

You are still covered by Original Medicare, but you are getting your Medicare services as a member of Tufts Medicare Preferred HMO Prime. This booklet gives you the details, including:

- What is covered by Tufts Medicare Preferred HMO Prime and what is not covered.
- How to get the care you need, including some rules you must follow.
- What you will have to pay for your health plan.
- What to do if you are unhappy about something related to getting your covered services.
- How to leave Tufts Medicare Preferred HMO Prime and other Medicare options that are available.

If you need to receive this booklet in a different format please call us so we can send you a copy. Section 1 of this booklet tells how to contact us.

Please tell us how we're doing.

We want to hear from you about how well we are doing as your health plan. You can call or write to us at any time (Section 1 of this booklet tells how to contact us). Your comments are always welcome, whether they are positive or negative. From time to time, we do surveys that ask our members to tell about their experiences with Tufts Medicare Preferred HMO Prime. If you are contacted, we hope you will participate in a member satisfaction survey. Your answers to the survey questions will help us know what we are doing well and where we need to improve.

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Section 1 Telephone numbers and other information for reference

How to contact Tufts Health Plan Medicare Preferred Customer Relations

If you have any questions or concerns, please call or write to Tufts Medicare Preferred Customer Relations. We will be happy to help you.

- CALL** 1-800-701-9000 This number is also on the cover of this booklet for easy reference. Calls to this number are free.
- TDD** 1-800-208-9562 This number requires special telephone equipment. It is on the cover of this booklet for easy reference. Calls to this number are free.
- FAX** 617-972-9405
- WRITE** Tufts Health Plan Medicare Preferred, P.O. Box 9181, Watertown, MA 02471-9181

How to contact the Medicare program and the 1-800-MEDICARE (TTY 1-877-486-2048) helpline

Medicare is the federal health insurance program for people 65 years of age or older, some people under age 65 with disabilities, and people with End Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant). CMS is the federal agency in charge of the Medicare program. CMS stands for Centers for Medicare & Medicaid Services. CMS contracts with and regulates Medicare Health Plans (including Tufts Medicare Preferred HMO Prime). Here are ways to get help and information about Medicare from CMS:

- Call **1-800-MEDICARE** (1-800-633-4227) toll free to ask questions or get free information booklets from Medicare. You can call this national Medicare helpline 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.
- Use a computer to look at www.medicare.gov, the official **government website for Medicare information**. This website gives you a lot of up-to-date information about Medicare and nursing homes and other current Medicare issues. It includes booklets you can print directly from your computer. It has tools to help you compare Medicare Advantage Plans and Prescription Drug Plans in your area. You can also search the “Helpful Contacts” section for the Medicare contacts in your state. If you do not have a computer, your local library or senior center may be able to help you visit this website using their computer.

SHINE (Serving Health Information Needs of Elders) – an organization in your state that provides free Medicare help and information

SHINE is a state organization paid by the federal government to give free health insurance information and help to people with Medicare. SHINE can explain your Medicare rights and protections, help you make complaints about care or treatment, and help straighten out problems with Medicare bills. SHINE has information about Medicare Advantage Plans and about Medigap (Medicare supplement insurance) policies. This includes information about whether to drop your Medigap policy while enrolled in the Medicare Advantage plan. This also includes special Medigap rights for people who have tried a Medicare Advantage Plan (like Tufts Medicare Preferred HMO Prime) for the first time. (Medicare Advantage is the new name for Medicare + Choice). Section 13 has more information about your Medigap guaranteed issue rights.

You can contact SHINE at 1-800-882-2003 (in-state calls only, press #2 for SHINE Counselor) TTY/TDD 1-800-872-0166, Monday – Friday, 9:00 a.m. – 5:00 p.m. You can also find the website for SHINE at www.medicare.gov on the web.

Massachusetts Peer Review Organization (MassPRO) / Quality Improvement Organization – a group of doctors and health professionals in your state who review medical care and handle certain types of complaints from patients with Medicare

“QIO” stands for Quality Improvement Organization. QIO is a group of doctors and other health care experts paid by the federal government to check on and help improve the care given to Medicare patients. There is a QIO in each state. QIO’s have different names, depending on which state they are in. In Massachusetts, the QIO is called Massachusetts Peer Review Organization (MassPRO). The doctors and other health experts in MassPRO review certain types of complaints made by Medicare patients. These include complaints about quality of care and complaints from Medicare patients who think the coverage for their hospital, skilled nursing facility, home health agency, or comprehensive outpatient rehabilitation stay is ending too soon. See Section 10 for more information about complaints.

You can contact MassPRO at Massachusetts Peer Review Organization, 245 Winter Street, Waltham, MA 02145. You can also call MassPRO at 1-800-252-5533 ext. 347.

Other organizations (including Medicaid, Social Security Administration)

Medicaid agency – a state government agency that handles health care programs for people with low incomes

Medicaid is a joint federal and state program that helps with medical costs for some people with low incomes and limited resources. Some people with Medicare are also eligible for Medicaid. Most health care costs are covered if you qualify for both Medicare and Medicaid. Medicaid also has programs that can help pay for your Medicare premiums and other costs, if you qualify. To find out more about Medicaid and its programs, contact MassHealth Customer Service Center, 55 Summer Street, Boston, MA 02110 or call 1-800-841-2900, TDD 1-800-497-4648. You can visit the MassHealth website at www.mass.gov/dma.

Social Security Administration

The Social Security Administration provides economic protection for Americans of all ages. Social Security programs include retirement benefits, disability, family benefits, survivors' benefits, and benefits for the aged, blind, and disabled. You can call the Social Security Administration toll free at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also visit www.ssa.gov on the web.

Railroad Retirement Board

If you get benefits from the Railroad Retirement Board, you can call your local Railroad Retirement Board office or 1-800-808-0772 (calls to this number are free). TTY users should call 312-751-4701. You can also visit www.rrb.gov on the web.

Employer (or "Group") Coverage

Because you get your benefits from your current or former employer, or your spouse's current or former employer, you can call your benefits administrator or Customer Relations if you have any questions about your benefits, plan premiums, or the open enrollment season.

Section 2 Getting the care you need, including some rules you must follow

2

Section 6 describes our coverage rules associated with our outpatient prescription drug coverage.

What is Tufts Medicare Preferred HMO Prime?

Now that you are enrolled in Tufts Medicare Preferred HMO Prime, you are getting your Medicare through Tufts Health Plan. Tufts Medicare Preferred HMO Prime is offered by Tufts Health Plan, and is an HMO for people with Medicare. The Medicare program pays us to manage health services for people with Medicare who are members of Tufts Medicare Preferred HMO Prime. (Tufts Medicare Preferred HMO Prime is **not** a Medicare supplement policy. See Section 15 for a definition of Medicare supplement policy. Medicare supplement policies are sometimes called “Medigap” insurance policies.) Tufts Health Plan provides medical services through Medicare-certified health care facilities. In addition, our health care professionals are in compliance with Medicare credentialing standards.

This booklet explains your benefits and services, what you have to pay, and the rules you must follow to get your care. Tufts Medicare Preferred HMO Prime gives you all the Medicare benefits and services that Medicare covers for everyone. We also give you some additional services, such as annual routine physical exams and routine hearing and vision exams.


Since Tufts Medicare Preferred HMO Prime is a Medicare HMO, this means that you will be getting most or all of your health services from the doctors, hospitals, and other health providers that are part of the Tufts Medicare Preferred HMO Prime network. Your primary care physician (PCP) has referral relationships with Tufts Medicare Preferred HMO Prime contracted providers and suppliers (called a “referral circle”) for all covered services. Your PCP’s referral circle includes physician specialists, skilled nursing facilities, durable medical equipment providers and other selected providers. The referral circle also might include a designated inpatient mental health facility that is different from the hospital that your PCP uses for other inpatient services.

Your PCP’s medical group has a contract with one particular hospital for inpatient and outpatient hospital services for Tufts Medicare Preferred HMO Prime members. Except in the case of emergencies, certain urgent care situations, or when you need tertiary care that is not available at the medical group’s contracted hospital, you will not have access to other Tufts Medicare Preferred HMO Prime network hospitals.

These doctors, hospitals, and other providers are the ones we are paying to provide your care, so they are the ones you must use (except in special situations such as emergencies).

Use your plan membership card instead of your red, white, and blue Medicare card

Tufts Medicare Preferred HMO Prime ID Card

TUFTS  Health Plan		HMO
<input checked="" type="checkbox"/> Medicare Preferred		\$10 PCP OV
Rx BIN	610415	\$15 Spec OV
Rx PCN	PCS	\$50 ER
Rx Grp	MB010200	
PCP	Mary Smith, M.D.	
Issuer	80840	
ID	Sxxxxxxxxx	
Name JOHN Q SAMPLE		CMS-H2256-016

Submit Medical Claims to:

Tufts Health Plan
Medicare Preferred
P.O. Box 9183
Watertown, MA 02471-9183

**For benefit information,
pre-authorization
or other assistance,**
call Tufts Health Plan
M-F, 8:30am – 5:00pm

Important Numbers:

Provider Relations: 1-800-279-9022
Customer Relations: 1-800-701-9000
TDD 1-800-208-9562
Mental Health: 1-800-208-9565
TDD: 1-866-244-4740

During the time you are a plan member and using plan services, **you *must* use your plan membership card instead of your red, white, and blue Medicare card to get covered services.** (See Section 4 for a definition and list of covered services.) Keep your red, white, and blue Medicare card in a safe place in case you need it later. If you get covered services using your red, white, and blue Medicare card instead of your Tufts Medicare Preferred HMO Prime membership card while you are a plan member, the Medicare program will not pay for these services and you may have to pay the full cost yourself.

Please carry your Tufts Medicare Preferred HMO Prime membership card with you at all times. You will need to show your card when you get covered services. You will also need it to get your prescriptions at the pharmacy (members who did not enroll in Medicare Part D prescription drug coverage still receive the Tufts Health Plan discount on drugs at participating pharmacies.) If your membership card is damaged, lost, or stolen, call Customer Relations right away and we will send you a new card.

Help us keep your membership record up to date

Tufts Health Plan has a membership record about you as a plan member. Doctors, hospitals, pharmacists, and other plan providers use this membership record to know what services and drugs are covered for you. The membership record has information from your enrollment form, including your address and telephone number. It shows your specific Tufts Medicare Preferred HMO Prime coverage, the Primary Care Physician you chose when you enrolled, and other information. Section 9 tells how we protect the privacy of your personal health information.

Please help us keep your membership record up to date by letting Customer Relations know right away if there are any changes to your name, address, or phone number, or if you go into a nursing home. Also, tell Customer Relations about any changes in health insurance coverage you have from other sources, such as from your employer, your spouse's employer, workers' compensation, Medicaid, or liability claims such as claims from an automobile accident. Call the number on the cover of this booklet to contact Customer Relations.

What is the geographic service area for Tufts Medicare Preferred HMO Prime?

The counties and parts of counties in our service area are listed below.

- Barnstable County
- Bristol County, except the following zip codes: 02715, 02718, 02764, 02779, 02780, 02783
- Essex County
- Hampden County
- Middlesex County
- Norfolk County
- Plymouth County, except the following zip codes: 02344, 02346, 02347, 02348, 02349
- Suffolk County
- Worcester County

Using plan providers to get services covered by Tufts Medicare Preferred HMO Prime

You will be using plan providers to get your covered services

Now that you are a member of Tufts Medicare Preferred HMO Prime, **you must use plan providers to get your covered services** with few exceptions.

- **What are “plan providers”?** “Providers” is the term we use for doctors, other health care professionals, hospitals, and other health care facilities that are licensed or certified by Medicare and by the state to provide health care services. We call them “plan providers” when they participate in Tufts Medicare Preferred HMO Prime. When we say that plan providers “participate in Tufts Medicare Preferred HMO Prime,” this means that we have arranged with them to coordinate or provide covered services to members of Tufts Medicare Preferred HMO Prime.
- **What are “covered services”?** “Covered services” is the general term we use in this booklet to mean all the medical care, health care services, supplies, and equipment that are covered by Tufts Medicare Preferred HMO Prime. Covered services are listed in the Benefits Chart in Section 4.

As we explain later, you will have to choose one of our plan providers to be your PCP, which stands for Prietary Care Physician. Your PCP will provide or arrange for most or all of your covered services. Care or services you get from non-plan providers will not be covered, with few exceptions such as emergencies. (When we say “non-plan providers,” we mean providers that are **not** part of Tufts Medicare Preferred HMO Prime.)

The Provider Directory gives you a list of plan providers

Every year as long as you are a member of Tufts Medicare Preferred HMO Prime, we will send you either a Provider Directory or an update to your Provider Directory, which gives you a list of plan providers. If you don't have the Provider Directory, you can get a copy from Customer Relations (call the number on the cover of this booklet).

A list of plan providers is available on our website. Go to www.tuftshealthplan.com and click on the Tufts Medicare Preferred logo.

You can ask Customer Relations for more information about plan providers, including their qualifications and experience. Customer Relations can give you the most up-to-date information about changes in plan providers and about which ones are accepting new patients.

Access to care and information from plan providers

You have the right to get timely access to plan providers and to all services covered by the plan.

("Timely access" means that you can get appointments and services within a reasonable period of time.)

You have the right to get full information from your doctors when you go for medical care. You have the right to participate fully in decisions about your health care, which includes the right to refuse care.

Please see Section 9 for more information about these and other rights you have, and what you can do if you think your rights have not been respected.

Choosing Your PCP (PCP means Primary Care Physician)

What is a "PCP"?

When you become a member of Tufts Medicare Preferred HMO Prime, you must choose a plan provider to be your PCP. Your PCP is a physician who meets state requirements and is trained to give you basic medical care. As we explain later, you will get your routine or basic care from your PCP. Your PCP will also coordinate the rest of the covered services you get as a plan member. For example, in order to see a specialist, you usually need to get your PCP's approval first (this is called getting a "referral" to a specialist).

How do you choose a PCP?

When you are deciding on a PCP, you may refer to our Provider Directory. Once you have made a choice, you should call Customer Relations (see the number on the front of this booklet). A Customer Relations representative will verify that the PCP you have chosen is accepting new patients. Members can change PCPs (as explained later in this section). If you are making a change, the change will be effective the 1st of the following month, and you will automatically receive a new member ID card in the mail reflecting this change. The name of your PCP will be printed on your membership card. If you want to be admitted to a particular hospital, or see a particular specialist check the Provider Directory, or speak with a Customer Relations representative to be sure your PCP of choice uses that hospital or makes referrals to that specialist.

Please note: If your current PCP is a Tufts Medicare Preferred HMO Prime contracted provider, you should check to see which hospital s/he uses for Tufts Medicare Preferred HMO Prime members. Although your PCP may have admitting privileges at a number of hospitals, s/he may use one particular hospital for Tufts Medicare Preferred HMO Prime members, and it may be a different hospital from one you have been referred to in the past.

Getting care from your PCP

You will usually see your PCP first for most of your routine health care needs. There are only a few types of covered services you can get on your own, without contacting your PCP first except as we explain later and in Section 4.

Your PCP will provide most of your care and will help arrange or coordinate the rest of the covered services you get as a plan member. This includes your x-rays, laboratory tests, therapies, care from doctors who are specialists, hospital admissions, and follow-up care. “Coordinating” your services includes checking or consulting with other plan providers about your care and how it is going. Each plan has certain plan specialists s/he uses for referrals, called a “referral circle.” If you need certain types of covered services or supplies, your PCP must give approval in advance (such as giving you a referral to see a specialist). In some cases, your PCP will also need to get prior authorization (prior approval). Since your PCP will provide and coordinate your medical care, you should have all of your past medical records sent to your PCP’s office. Section 9 tells how we will protect the privacy of your medical records and personal health information.

What if you need medical care when your PCP’s office is closed?

What to do if you have a medical emergency or urgent need for care

In an emergency, you should get care immediately. You do **not** have to contact your PCP or get permission in an emergency. You can dial 911 for immediate help by phone or go directly to the nearest emergency room, hospital, or urgent care center. Section 3 tells what to do if you have a medical emergency or urgent need for care.

What to do if it is not a medical emergency

If you need to talk with your PCP or get medical care when the PCP’s office is closed, and it is *not* a medical emergency, call his or her office for instructions. There will always be a physician on call to help you. For our hearing or speech-impaired members with TTY/TDD machines, you may call the Massachusetts Relay Association at 1-800-439-0183 (TTY 1-800-439-2370) for assistance contacting your PCP after hours.

See Section 3 for more information about what to do if you have an urgent need for care.

Getting care from specialists

When your PCP thinks that you need specialized treatment, he or she will give you a referral (approval in advance) to see a plan specialist within his/her referral circle. A specialist is a doctor who provides health care services for a specific disease or part of the body. Specialists include oncologists (who care for patients with cancer), cardiologists (who care for patients with heart conditions), and orthopedists (who care for patients with certain bone, joint, or muscle conditions). For some types of referrals to plan specialists, your PCP may need to get approval in advance from Tufts Health Plan (this is called getting “prior authorization”).

It is very important to get a referral from your PCP before you see a plan specialist (there are a few exceptions, including routine women’s health care that we explain later in this section). **If you don’t**

have a referral before you receive services from a specialist, you may have to pay for these services yourself. If the specialist wants you to come back for more care, check first to be sure that the referral you got from your PCP covers more visits to the specialist.

Your PCP's medical group has a contract with one particular hospital for inpatient and outpatient hospital services for Tufts Medicare Preferred HMO Prime members. Except in the case of emergencies, certain urgent care situations, or when you need tertiary care that is not available at the medical group's contracted hospital, you will not have access to other Tufts Medicare Preferred HMO Prime network hospitals.

Referrals are limited to inpatient facilities, providers and suppliers that are part of your PCP's referral circle. If there are specific specialists you want to use, find out whether your PCP sends patients to these specialists. Each plan PCP has certain plan specialists s/he uses for referrals. This means that the **Tufts Medicare Preferred HMO Prime specialists you can use may depend on which person you choose to be your PCP.** You can notify us at any time during the month that you wish to change your PCP if you want to see a plan specialist that your current PCP cannot refer you to. Your change request will be effective the first of the following month. Later in this section, under "How to Change your PCP" we tell you how to change your PCP. If there are specific hospitals you want to use, find out whether your PCP uses these hospitals.

There are some services you can get on your own, without a referral

As explained previously, you will get most of your routine or basic care from your PCP, and your PCP will coordinate the rest of the covered services you get as a plan member. If you get services from any doctor, hospital, or other health care provider without getting a referral in advance from your PCP, you may have to pay for these services yourself – even if you get the services from a plan provider. *But there are a few exceptions:* you can get the following services on your own, without a referral or approval in advance from your PCP. You still have to pay your cost sharing, as appropriate, co-payment for these services.

- Routine women's health care, which includes breast exams, mammograms (x-rays of the breast), Pap tests, and pelvic exams. This care is covered without a referral from your PCP *only* if you get it from a plan provider.
- Flu shots and pneumonia vaccinations (as long as you get them from a plan provider).
- Routine hearing and vision exams (as long as you get them from a plan provider).
- Emergency services, whether you get these services from plan providers or non-plan providers (see Section 3 for more information).
- Urgently needed care that you get from non-plan providers when you are temporarily outside the plan's service area. Also, urgently needed care that you get from non-plan providers when you are in the service area but, because of unusual or extraordinary circumstances, the plan providers are temporarily unavailable or inaccessible. (See Section 3 for more information about urgently needed care. Earlier in this section, we explain the plan's service area.)
- Renal dialysis (kidney) services that you get when you are temporarily outside the plan's service area. If possible, please let us know before you leave the service area where you are going to be so we can help arrange for you to have maintenance dialysis while outside the service area.

Getting care when you travel or are away from the plan's service area

If you need care when you are outside the service area, your coverage is limited. The only services we cover when you are outside our service area are care for a medical emergency, urgently needed care, renal dialysis, and care that Tufts Health Plan or a plan provider has approved in advance. See Section 3 for more information about care for a medical emergency and urgently needed care. If you have questions about what medical care is covered when you travel, please call Customer Relations at the telephone number on the cover of this booklet. See Section 6 for more information about how to fill your outpatient prescriptions when you travel or are away from the plan service area.

How to change your PCP

You may change your PCP for any reason, at any time. To change your PCP, call Customer Relations at the number on the cover of this booklet. When you call, be sure to tell Customer Relations if you are seeing specialists or getting other covered services that needed your PCP's approval (such as home health services and durable medical equipment). Customer Relations will help make sure that you can continue with the specialty care and other services you have been getting when you change your PCP. They will also check to be sure the PCP you want to switch to is accepting new patients. Customer Relations will change your membership record to show the name of your new PCP, and tell you when the change to your new PCP will take effect. They will also send you a new membership card that shows the name of your new PCP. We suggest that you make an appointment with, and arrange for your records to be transferred to, your new PCP.

What if your doctor leaves Tufts Medicare Preferred HMO Prime?

Sometimes a PCP, specialist, clinic, or other plan provider you are using might leave the plan. If this happens, you will have to switch to another provider who is part of Tufts Medicare Preferred HMO Prime. If your PCP leaves Tufts Medicare Preferred HMO Prime, we will let you know, and help you switch to another PCP so that you can keep getting covered services.

Section 3 Getting care if you have a medical emergency or an urgent need for care

What is a “medical emergency”?

A “medical emergency” is when **you reasonably believe that your health is in serious danger** – when every second counts. A medical emergency includes severe pain, a bad injury, a serious illness, or a medical condition that is quickly getting much worse.

What should you do if you have a medical emergency?

If you have a medical emergency:

- Get medical help as quickly as possible. Call 911 for help or go to the nearest emergency hospital, or urgent care center. **You do not need to get approval or a referral first from your PCP (Primary Care Physician) or other plan provider.** (Section 2 tells about your PCP and plan providers.)
- Make sure that Tufts Health Plan and your PCP know about your emergency, because we both will need to be involved in following up on your emergency care. You or someone else should call to tell your PCP about your emergency care as soon as possible, preferably within 48 hours. The phone number to call Tufts Health Plan is on the back of your membership card.

Tufts Medicare Preferred HMO Prime and Your PCP will help manage and follow up on your emergency care

Tufts Health Plan Medicare Preferred HMO Prime or your PCP will talk with the doctors who are giving you emergency care to help manage and follow up on your care. When the doctors who are giving you emergency care say that your condition is stable and the medical emergency is over, what happens next is called “post-stabilization care.” Your follow-up care (post-stabilization care) will be covered according to Medicare guidelines. In general, we will try to arrange for plan providers to take over your care as soon as your medical condition and the circumstances allow.

What is covered if you have a medical emergency?

- You can get covered emergency medical care whenever you need it, anywhere in the world. See Section 6 for more information on how we cover outpatient prescription drugs in an emergency situation while you are outside the service area.
- Ambulance services are covered anywhere in the world in situations where other means of transportation would endanger your health.

What if it wasn't really a medical emergency?

Sometimes it can be hard to know if you have a real medical emergency. For example, you might go in for emergency care – thinking that your health is in serious danger – and the doctor may say that it was not a medical emergency after all. If this happens, you are still covered for the care you got to determine what was wrong, (as long as you thought your health was in serious danger, as explained in “What is a ‘medical emergency’” on the previous page). However, please note that:

- If you get any additional care after the doctor says it was *not* a medical emergency, we will pay our portion of the covered additional care **only if you get it from a plan provider within your PCP's referral network.**
- If you get any additional care from a *non-plan provider* after the doctor says it was not a medical emergency, we will usually *not* cover the additional care. There is an exception: we will pay our portion of the covered additional care from a non-plan provider if you are out of our service area, as long as the additional care you get meets the definition of “urgently needed care” that is given below.

What is “urgently needed care”? (This is different from a medical emergency)

“Urgently needed care” is **when you need medical attention right away for an unforeseen illness or injury**, and it is not reasonable given the situation for you to get medical care from your PCP or other plan providers. In these cases, your health is *not* in serious danger. As we explain later, how you get “urgently needed care” depends on whether you need it when you are in the plan's service area, or outside the plan's service area. Section 2 tells about the plan's service area.

What is the difference between a “medical emergency” and “urgently needed care”?

The main difference between an urgent need for care and a medical emergency is in the danger to your health. “Urgently needed care” is when you need medical help immediately, but your health is not in serious danger. A “medical emergency” is when you believe that your health is in serious danger.

Getting urgently needed care when you are in the plan's service area

If you have a sudden illness or injury that is not a medical emergency, and you are in the plan's service area, please call your PCP. If his or her office has closed for the day, listen for instructions. There will always be a doctor on call to help you. For our hearing or speech-impaired members with TTY/TDD machines, you may call the Massachusetts Relay Association at 1-800-439-0183 (TTY/TDD 1-800-439-2370) for assistance contacting your PCP after hours. Keep in mind that if you have an urgent need for care while you are in the plan's service area, we expect you to get this care from plan providers. In most cases, we will not pay for urgently needed care that you get from a non-plan provider while you are in the plan's service area.

How to get urgently needed care

Tufts Medicare Preferred HMO Prime covers urgently needed care that you get from any provider worldwide. If you are outside the service area, you will need to return to the service in order to be covered for non-urgent care. (See Section 6 for more information on filling your prescription drugs when you are getting urgently needed care and when you are outside the plan's service area.)

Section 4 Benefits Chart – a list of the covered services you get as a member of Tufts Medicare Preferred HMO Prime

What are “covered services”?

This section describes the medical benefits and coverage you get as a member of Tufts Medicare Preferred HMO Prime. **“Covered services” means the medical care, services, supplies, and equipment that are covered by Tufts Medicare Preferred HMO Prime.** This section has a Benefits Chart that gives a list of your covered services and tells what you must pay for each covered service. The section that follows (Section 5) tells about **services that are *not* covered** (these are called “exclusions”). Section 5 also tells about limitations on certain services.

There are some conditions that apply in order to get covered services

Some general requirements apply to *all* covered services

The covered services listed in the Benefits Chart in this section are covered only when *all* requirements listed below are met:

- Services must be provided according to the Medicare coverage guidelines established by the Medicare program.
- The medical care, services, supplies, and equipment that are listed as covered services must be medically necessary. Certain preventive care and screening tests are also covered. (See Section 15 for a definition of “medically necessary.”)
- With few exceptions, covered services must be provided by plan providers, be approved in advance by plan providers, or be authorized by Tufts Health Plan. The exceptions are care for a medical emergency, urgently needed care outside the service area, and renal (kidney) dialysis you get when you are outside the plan’s service area.

In addition, some covered services require “prior authorization” in order to be covered

Most of the covered services listed in the Benefits Chart in this section are covered only if your doctor or other plan provider gets “prior authorization” (approval in advance) from Tufts Health Plan. Covered services that need prior authorization are marked in the Benefits Chart by an asterisk (*) and a footnote.

Benefits Chart – a list of covered services

Benefits chart – your covered services	What you must pay when you get these covered services
Inpatient Services	
<p>Inpatient hospital care*</p> <p>For more information about hospital care, see Section 7.</p> <p>Covered services include, but are not limited to, the following:</p> <ul style="list-style-type: none"> • Semiprivate room (or a private room if medically necessary). • Meals including special diets. • Regular nursing services. • Costs of special care units (such as intensive or coronary care units). • Drugs and medications. • Lab tests. • X-rays and other radiology services. • Necessary surgical and medical supplies. • Use of appliances, such as wheelchairs. • Operating and recovery room costs. • Physical therapy, occupational therapy, and speech therapy. • <i>Under certain conditions, the following types of transplants are covered:</i> corneal, kidney, pancreas, heart, liver, lung, heart/lung, bone marrow, stem cell, intestinal/multivisceral. See Section 7 for more information about transplants. • Blood - Coverage of whole blood and packaged red cells, including storage and administration, begins with the first pint of blood that you need. • Physician Services. 	<p><u>For care in an Acute hospital</u>, you are covered for unlimited days each benefit period. See Section 15 for the definition of “benefit period.”</p> <p>You pay one initial deductible of \$200 for services received at a network hospital. There is a \$200 maximum out-of-pocket limit every year.</p> <p>If you get inpatient care after your emergency condition has been stabilized at a non-plan hospital that the plan has approved, your cost is the same cost sharing you would pay at a plan hospital.</p> <p><u>For care in a Rehabilitation or Long-Term Care Hospital</u> you are covered 100% up to 90 days each benefit period. You may use your 60-lifetime reserve days to supplement care in rehabilitation or long-term hospitals. Coverage is limited by prior partial or complete use of these days, which may only be used once in a lifetime.</p> <p>You pay \$0 for services received in a rehabilitation or long-term care hospital.</p> <p>See Section 15 for the definition of “benefit period.”</p>

*Except in an emergency, prior authorization from Tufts Health Plan is required before you get this service.

Benefits chart – your covered services	What you must pay when you get these covered services
<p>Inpatient mental health care*</p> <p>Includes mental health care services that require a hospital stay. There is a 190-day lifetime limit for mental health care and substance abuse services provided in a free standing psychiatric hospital. The benefit is limited by prior partial or complete use of a 190-day lifetime treatment in a psychiatric hospital. The 190-day limit does not apply to mental health and substance abuse services provided in a psychiatric unit of a general hospital.</p> <p>For inpatient mental health/substance abuse services, you will be required to use the hospital within your primary care physician's (PCP's) referral circle designated for mental health services. This may require a transfer from the hospital your PCP uses for medical and surgical services to the facility designated for mental health services.</p>	<p>You pay \$0 for each hospital stay up to a 190-day lifetime limit in a psychiatric hospital.</p> <p>You pay \$0 for each hospital stay in a general hospital.</p>

Benefits chart – your covered services	What you must pay when you get these covered services
<p>Skilled nursing facility care *</p> <p>For more information about skilled nursing facility care, see Section 7.</p> <p>You are covered for up to 100 days each benefit period. No prior hospital stay is required. Covered services include, but are not limited to, the following:</p> <ul style="list-style-type: none"> • Semiprivate room (or a private room if medically necessary). • Meals, including special diets. • Regular nursing services. • Physical therapy, occupational therapy, and speech therapy. • Drugs (this includes substances that are naturally present in the body, such as blood clotting factors). • Blood - Coverage of whole blood and packaged red cells, including storage and administration, begins with the first pint of blood that you need. • Medical and surgical supplies. • Laboratory tests. • X-rays and other radiology services. • Use of appliances such as wheelchairs. • Physician services. 	<p>You pay \$0 for services in a skilled nursing facility.</p> <p>See Section 15 for the definition of “benefit period.”</p>

*Prior authorization from Tufts Health Plan is required before you get this service.

Benefits chart – your covered services	What you must pay when you get these covered services
<p>Inpatient services* (when the hospital or SNF days are not or are no longer covered)</p> <p>For more information, see Section 7.</p> <ul style="list-style-type: none"> • Physician services. • Tests (like X-ray or lab tests). • X-ray, radium, and isotope therapy including technician materials and services. • Surgical dressings, splints, casts and other devices used to reduce fractures and dislocations. • Prosthetic devices (other than dental) that replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices. • Leg, arm, back, and neck braces; trusses, and artificial legs, arms, and eyes including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition. • Physical therapy, speech therapy, and occupational therapy. 	<p>You pay \$0 for Medicare-covered services.</p>
<p>Home health care*</p> <p>For more information about home health care, see Section 7.</p> <p>Home Health Agency Care:</p> <ul style="list-style-type: none"> • Part-time or intermittent skilled nursing and home health aide services. • Physical therapy, occupational therapy, and speech therapy. • Medical social services. • Medical equipment and supplies. 	<p>You pay \$0 for Medicare-covered home health visits and supplies.</p>

*Prior authorization from Tufts Health Plan is required before you get this service.

Benefits chart – your covered services	What you must pay when you get these covered services
<p>Hospice care</p> <p>For more information about hospice services, see Section 7.</p> <ul style="list-style-type: none"> • Drugs for symptom control and pain relief, short-term respite care, and other services not otherwise covered by Medicare. • Home care. • Hospice consultation services (one time only) for a terminally ill individual who has not elected the hospice benefit. 	<p>When you enroll in a Medicare-certified Hospice, your hospice services are paid by Medicare (see Section 7 for more information about hospice services).</p>
<p>Outpatient Services</p>	
<p>Physician services, including doctor office visits</p> <ul style="list-style-type: none"> • Office visits, including medical and surgical care in a physician's office or certified ambulatory surgical center. • Consultation, diagnosis, and treatment by a specialist. • Second opinion by another plan provider prior to surgery. • Outpatient hospital services. • Non-routine dental care (covered services are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease, or services that would be covered when provided by a doctor). 	<p>You pay \$10 for each covered visit with your PCP.</p> <p>You pay \$15 for each covered visit with a specialist.</p> <p>You pay \$0 for diagnostic and testing services, initial evaluations and visits, and medical management services to treat patients with Alzheimer's disease or dementia.</p>
<p>Chiropractic services</p> <ul style="list-style-type: none"> • Manual manipulation of the spine to correct subluxation. Please see Section 5 for exclusions/limitations to this benefit. 	<p>You pay \$15 for each Medicare-covered visit.</p>

Benefits chart – your covered services	What you must pay when you get these covered services
<p>Podiatry services</p> <ul style="list-style-type: none"> • Treatment of injuries and diseases of the feet (such as hammer toe or heel spurs). • Routine foot care for members with certain medical conditions affecting the lower limbs. 	<p>You pay \$15 for each Medicare-covered visit</p>
<p>Outpatient mental health care (including Partial Hospitalization Services)</p> <p>Mental health services provided by a doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant, or other mental health care professional as allowed under applicable state laws. "Partial hospitalization" is a structured program of active treatment that is more intense than the care received in your doctor's or therapist's office and is an alternative to inpatient hospitalization.</p> <p>The hospital may be different than the one your PCP uses for medical and surgical procedures.</p>	<p>You pay \$0 for partial hospitalization services if a physician certifies that inpatient treatment would be necessary without it.</p> <p>You pay \$15 for Medicare-covered mental health services for individual/group therapy visit(s).</p> <p>Exceptions:</p> <p>You pay \$0 for brief office visits for the sole purpose of monitoring or changing drugs.</p> <p>You pay \$0 for diagnostic and testing services; initial evaluations and visits and medical management services to treat patients with Alzheimer's disease or dementia.</p>
<p>Outpatient substance abuse services</p> <p>Mental health services provided by a doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant, or other mental health care professional as allowed under applicable state laws. "Partial hospitalization" is a structured program of active treatment that is more intense than the care received in your doctor's or therapist's office and is an alternative to inpatient hospitalization.</p> <p>The hospital may be different than the one your PCP uses for medical and surgical procedures.</p>	<p>You pay \$15 for Medicare-covered services for individual/group therapy visit(s) except for partial hospitalization services.</p> <p>You pay \$0 for partial hospitalization services when connected with the treatment of substance abuse if a physician certifies that inpatient substance abuse treatment would be necessary without it.</p>

Benefits chart – your covered services	What you must pay when you get these covered services
<p>Outpatient services / surgery</p>	<p>You pay 20% of the Medicare allowable amount if the provider accepts assignment up to a maximum of \$50 per day for outpatient hospital and ambulatory surgical center procedures including most endoscopies.</p> <p>You pay \$0 for all large bowel preventive-screening procedures, such as colonoscopy without a biopsy.</p> <p>If a surgical procedure is performed during a screening procedure, the co-pay may apply.</p> <p>You do not pay this co-insurance if you are admitted to the hospital within 24 hours of, or on the same day as, an outpatient procedure being performed.</p>
<p>Ambulance services</p> <p>Includes ambulance services to an institution (like a hospital or SNF), to a dialysis facility, from an institution to another institution, from an institution to your home, and services dispatched through 911, where other means of transportation could endanger your health.</p>	<p>You pay \$0 for Medicare-covered ambulance services.</p> <p>Please see Section 5 for exclusions/limitations to this benefit.</p>

Benefits chart – your covered services	What you must pay when you get these covered services
<p>Emergency care</p> <p>For more information, see Section 3.</p> <p>Worldwide coverage for inpatient or outpatient services that are:</p> <ul style="list-style-type: none">• Given by a provider qualified to give emergency services, and• Needed to evaluate or stabilize a medical emergency condition	<p>You pay \$50 for each Medicare-covered emergency room visit; you do not pay this amount if you are admitted to the hospital within 24 hours for the same condition (refer to Inpatient Services in this section for the hospital deductible that may apply.)</p> <p>If you get inpatient care at a non-plan hospital after your emergency condition is stabilized, your cost is the cost sharing you would pay at a plan hospital.</p>
<p>Urgently needed care</p> <p>For more information, see Section 3.</p> <p>Worldwide coverage</p>	<p>You pay:</p> <ul style="list-style-type: none">• \$10 for each Medicare-covered urgently needed care office visit to your PCP,• \$15 for each specialist office visit• \$50 for each Medicare-covered urgently needed care emergency room visit. You do not pay the \$50 if you are admitted to the hospital within 24 hours for the same condition (refer to Inpatient Services in this section for the hospital deductible which may apply).

Benefits chart – your covered services	What you must pay when you get these covered services
<p>Outpatient rehabilitation services (physical therapy, occupational therapy, cardiac rehabilitation, and speech and language therapy)</p> <p>Cardiac rehabilitation therapy covered for patients who have had a heart attack in the last 12 months, have had coronary bypass surgery, have stable angina pectoris, have had heart valve repair/replacement, have had percutaneous transluminal coronary angioplasty (PTCA) or coronary stenting, or have had a heart or heart/lung transplant.</p> <p>Physical therapy, occupational therapy and speech/language therapy are covered when ordered or authorized by your PCP for medically necessary evaluation and treatment.</p>	<p>You pay \$0 for each Medicare-covered occupational therapy, cardiac rehabilitation, physical therapy and/or speech/language therapy visit.</p>
<p>Durable medical equipment and related supplies *- such as wheelchairs, crutches, hospital bed, IV infusion pump, oxygen equipment, nebulizer, and walker. (See definition of "durable medical equipment" in Section 15).</p>	<p>You pay \$0 for Medicare-covered items and related supplies.</p>
<p>Prosthetic devices and related supplies* -</p> <p>(other than dental) which replace a body part or function. These include colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic devices, and repair and/or replacement of prosthetic devices. Also includes some coverage following cataract removal or cataract surgery - see "Vision Care" later for more detail.</p>	<p>You pay \$0 for Medicare-covered items and related supplies.</p>

*Except in an emergency, prior authorization from Tufts Health Plan is required before you get this service.

Benefits chart – your covered services	What you must pay when you get these covered services
<p>Diabetes self-monitoring, training and supplies - for all people who have diabetes (insulin and non-insulin users).</p> <ul style="list-style-type: none"> • Blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose control solutions for checking the accuracy of test strips and monitors. • One pair per calendar year of therapeutic shoes for people with diabetes who have severe diabetic foot disease, including fitting of shoes or inserts. • Self-management training is covered under certain conditions. • <i>For persons at risk of diabetes:</i> Fasting plasma glucose tests covered as medically necessary. 	<p>You pay \$0 for Diabetes self-monitoring training or Diabetes supplies.</p>
<p>Medical nutrition therapy - for people with diabetes, renal (kidney) disease (but not on dialysis), and after a transplant when referred by your doctor.</p>	<p>You pay \$0 for Medicare-covered services.</p>
<p>Outpatient diagnostic tests and therapeutic services and supplies</p> <ul style="list-style-type: none"> • X-rays. • Radiation therapy. • Surgical supplies, such as dressings. • Supplies, such as splints and casts. • Laboratory tests. • Blood - Coverage of whole blood and packaged red cells, including storage and administration, begins with the first pint of blood that you need. 	<p>You pay \$0 for each Medicare-covered service.</p>

Benefits chart – your covered services	What you must pay when you get these covered services
Preventive Care and Screening Tests	
<p>Bone mass measurements</p> <p><i>For qualified individuals (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered every 2 years or more frequently if medically necessary: procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician's interpretation of the results.</i></p>	<p>You pay \$0 for Medicare-covered services.</p>
<p>Colorectal screening</p> <p><i>For people 50 and older, the following are covered:</i></p> <ul style="list-style-type: none"> • Flexible sigmoidoscopy (or screening barium enema as an alternative) every 48 months. • Fecal occult blood test, every 12 months. <p><i>For people at high risk of colorectal cancer, the following are covered:</i></p> <ul style="list-style-type: none"> • Screening colonoscopy (or screening barium enema as an alternative) every 24 months. <p><i>For people not at high risk of colorectal cancer, the following is covered:</i></p> <ul style="list-style-type: none"> • Screening colonoscopy every 10 years, but not within 48 months of a screening sigmoidoscopy. 	<p>You pay \$0 for Medicare-covered screening.</p> <p>If these services/screenings are provided in conjunction with a physician visit, the physician co-pay may apply (\$10 PCP, \$15 specialist).</p>

Benefits chart – your covered services	What you must pay when you get these covered services
<p>Immunizations</p> <ul style="list-style-type: none"> • Pneumonia vaccine. As explained in Section 2, you can get this service on your own, without a referral from your PCP as long as you get the service from a plan provider. • Flu shots, once a year in the fall or winter. As explained in Section 2, you can get this service on your own, without a referral from your PCP (as long as you get the service from a plan provider). • <i>If you are at high or intermediate risk of getting Hepatitis B:</i> Hepatitis B vaccine. • Other covered vaccines if you are at risk. • All other preventive vaccines are covered under Part D. 	<p>You pay \$0 for the pneumonia, flu and Hepatitis vaccines.</p> <p>If these services/screenings are provided in conjunction with a physician visit, the physician co-pay may apply (\$10 PCP, \$15 specialist).</p> <p>See Section 5 for exclusions/limitations to this benefit.</p>
<p>Mammography screening</p> <p>As explained in Section 2, you can get this service on your own, without a referral from your PCP as long as you get it from a plan provider:</p> <ul style="list-style-type: none"> • One baseline exam between the ages of 35 and 39. • One screening every 12 months for women age 40 and older. 	<p>You pay \$0 for Medicare-covered services.</p>
<p>Pap smears, pelvic exams, and clinical breast exam</p> <p>As explained in Section 2, you can get these routine women's health services on your own, without a referral from your PCP as long as you get the services from a plan provider:</p> <ul style="list-style-type: none"> • For all women, Pap tests, pelvic exams, and clinical breast exams are covered once every 12 months. 	<p>You pay \$0 for Medicare-covered services.</p> <p>If these services/screenings are provided in conjunction with a physician visit, the physician co-pay may apply (\$10 PCP, \$15 specialist).</p>

Benefits chart – your covered services	What you must pay when you get these covered services
Prostate cancer screening exams <i>For men age 50 and older, the following are covered once every 12 months:</i> <ul style="list-style-type: none"> • Digital rectal exam. • Prostate Specific Antigen (PSA) test. 	<p>You pay \$0 for Medicare-covered services.</p> <p>If these services/screenings are provided in conjunction with a physician visit, the physician co-pay may apply (\$10 PCP, \$15 specialist).</p>
Cardiovascular disease testing <p>Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease). Cholesterol and other lipid or triglyceride level blood tests for the early detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease). We will cover these tests as medically necessary.</p>	<p>You pay \$0 for Medicare-covered services.</p> <p>If these services/screenings are provided in conjunction with a physician visit, the physician co-pay may apply (\$10 PCP, \$15 specialist).</p>
Physical exams <p>One routine physical exam each year.</p>	<p>You pay \$10 for the exam with your PCP.</p>
Other Services	
Renal Dialysis (Kidney) <ul style="list-style-type: none"> • Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in Sections 2 and 3). • Inpatient dialysis treatments (if you are admitted to a hospital for special care). • Self-dialysis training (includes training for you and others for the person helping you with your home dialysis treatments). • Home dialysis equipment and supplies. • Certain home support services (such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and check your dialysis equipment and water supply). 	<p>You pay \$0 for Medicare-covered services within the service area when provided or authorized by your PCP. No referral is required when temporarily outside of the service area.</p>

Benefits chart – your covered services	What you must pay when you get these covered services
<p data-bbox="155 226 537 275">Prescription Drugs</p> <p data-bbox="170 302 880 373">Prescription Drugs Covered for Members Tufts Medicare Preferred HMO Prime:</p> <p data-bbox="170 394 829 466"><u>Prescription Drugs Covered under Original Medicare:</u></p> <p data-bbox="170 493 883 567">"Drugs" includes substances that are naturally present in the body, such as blood clotting factors.</p> <ul data-bbox="170 588 946 1659" style="list-style-type: none">• Drugs that usually are not self-administered by the patient and are injected while receiving physician services. Tufts Medicare Preferred HMO Prime also covers some drugs that are "usually not self-administered" even if you inject them at home.• Drugs you take using durable medical equipment (such as nebulizers) that was authorized by Tufts Health Plan.• Clotting factors you give yourself by injection if you have hemophilia.• Immunosuppressive drugs, if you have had an organ transplant that was covered by Medicare.• Injectable osteoporosis drugs, if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot self-administer the drug.• Antigens.• Certain oral anti-cancer drugs and anti-nausea drugs.• Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary, topical anesthetics, Erythropoietin (Epogen®) or Epoetin alfa, and Darboetin Alfa (Aranesp®).• Intravenous Immune Globulin for the treatment of primary immune deficiency diseases in your home.	<p data-bbox="987 478 1458 552">There is no benefit limit on drugs covered under Original Medicare.</p> <p data-bbox="987 579 1425 726">You pay 20% of the Medicare approved charge for Medicare-covered immunosuppressive drugs.</p> <p data-bbox="987 753 1458 827">You pay \$0 for other drugs covered under Original Medicare.</p>

Benefits chart – your covered services
What you must pay when you get these covered services
Prescription Drugs continued:

Other outpatient prescription drugs are covered by Tufts Medicare Preferred HMO Prime, such as antibiotics and high blood pressure medication are covered because you have enrolled for Medicare Prescription Drug coverage.

"Covered drugs" is the general term we use to mean all of the outpatient prescription drugs that are covered by Tufts Medicare Preferred HMO Prime. Refer to Section 6 for further details about your coverage.

Section 6 explains about the prescription drug benefit, including rules you must follow to have prescriptions covered. Section 6 also tells about drugs that are not covered by this benefit.

You pay the co-payments listed below for covered outpatient prescription drugs.

On an annual basis: Until your out of pocket costs reach \$3,850, you pay:

\$10 - \$50 co-payment for up to a 30-day supply at an in-network pharmacy.

\$30 - \$150 co-payment for up to a 90-day supply at an in-network pharmacy.

\$20 - \$100 co-payment for up to a 90-day supply mail order.

\$10 - \$50 co-payment for up to a 30-day supply at an out-of-network pharmacy. In addition to the co-payment, you may pay the difference between what we would pay for a prescription at an in-network pharmacy and what the out-of-network pharmacy charged for your prescription.

After your out-of-pocket drug costs reach \$3,850, you pay:

\$2 - \$14 co-payment for all drugs on our list of covered drugs.

Benefits chart – your covered services		What you must pay when you get these covered services
Additional Benefits		
Dental services Services by a dentist are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic disease, or services that would be covered when provided by a doctor.		You pay \$15 for each office visit. See Section 5 for exclusions/limitations to this benefit.
Hearing services <ul style="list-style-type: none">• Diagnostic hearing exams• Routine hearing tests• Hearing Aids		You pay \$15 for a Medicare-covered hearing exam. You pay \$15 for each routine hearing test up to 1 test each calendar year. You pay all charges over the \$500 hearing aid allowance provided every three years.
Wigs Wigs for cancer and leukemia patients		Cancer and leukemia patients pay any amount over \$350 for wigs each calendar year.

Benefits chart – your covered services**What you must pay when you get these covered services****Vision care**

1. Outpatient physician services for eye care	1. You pay \$15 for each Medicare-covered outpatient visit.
2. One routine eye exam each calendar year	2. You pay \$15 for each annual routine eye exam. No referral is necessary for annual routine exams, but you must use plan providers.
3. For people who are at high risk of glaucoma, such as people with a family history of glaucoma, people with diabetes, and African-Americans who are age 50 and older: glaucoma screening once per year	3. You pay \$15 for each Medicare-covered outpatient visit.
4. One pair of standard eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens. Corrective lenses/frames (and replacements) needed after a cataract removal without a lens implant (Tints, anti-reflective coating, U-V lenses or oversize lenses are covered only when deemed medically necessary by the treating physician)	4. You pay \$0 for one pair of standard eyeglasses or contact lenses after cataract surgery. Replacement also covered.
5. One pair of standard eyeglasses every calendar year (includes one pair of standard frames and single vision, bifocal or trifocal lenses) or contact lenses per prescription change for Keratoconus, Anisometropia (more than 3.0 diopters), or high myopia (more than 7.0 diopters)	5. You pay \$0 for one pair of standard eyeglasses or contact lenses for Keratoconus, Anisometropia or high myopia.
6. One pair of eyeglasses (prescription lenses and frames) every calendar year. Note: this \$69 benefit cannot be combined with the standard eyeglasses/contact lenses benefits described above.	6. You pay all charges over the \$69 calendar year allowance and you must use plan providers.

Benefits chart – your covered services	What you must pay when you get these covered services
<p data-bbox="154 254 777 348">Health and wellness education programs</p> <p data-bbox="170 380 839 411">Programs focused on clinical health conditions.</p> <p data-bbox="170 443 462 474"><u>Diabetes Programs</u></p> <ul data-bbox="170 495 586 527" style="list-style-type: none">• Annual educational mailing <p data-bbox="170 548 630 579"><u>Adult Immunization Programs</u></p> <ul data-bbox="170 600 924 762" style="list-style-type: none">• Annual educational brochure to members on the importance of flu vaccine, pneumonia vaccine, and tetanus vaccine• Annual flu vaccine reminder call <p data-bbox="170 783 630 814"><u>Smoking Cessation Programs</u></p> <ul data-bbox="170 835 940 1266" style="list-style-type: none">• Tufts Medicare Preferred covers intermediate and intensive smoking cessation counseling when Medicare coverage criteria are met. Two cessation attempts are covered per year. Each attempt may include a maximum of four intermediate or intensive sessions, with the total annual benefit covering up to eight sessions in a 12-month period. All plan authorization and in and out-of-network requirements apply.• Smoking cessation telephonic counseling is also available through QuitWorks. <p data-bbox="203 1287 924 1402">If you are ready to quit or are thinking about it, ask your doctor about QuitWorks, or visit www.trytostop.org, or call 1-800-TRY-TO-STOP.</p> <ul data-bbox="170 1423 919 1493" style="list-style-type: none">• Check your Tufts Medicare Preferred formulary for covered smoking cessation agents.	<p data-bbox="984 443 1386 474">You pay \$0 for this program.</p> <p data-bbox="984 558 1386 590">You pay \$0 for this program.</p> <p data-bbox="984 783 1471 814">Office visit co-payment may apply.</p> <p data-bbox="984 1203 1386 1234">You pay \$0 for this program.</p> <p data-bbox="984 1423 1430 1528">Prescription drug co-payments apply. see “Prescription Drugs” for more details.</p>

What if you have problems getting services you believe are covered for you?

If you have any concerns or problems getting the services you believe are covered as a member, we want to help. Please call us at Customer Relations at the telephone number on the cover of this booklet. You have the right to make a complaint if you have problems related to getting services or payment for services that you believe are covered as a member. See Section 10 for information about making a complaint.

Can your benefits change during the year?

Generally your benefits will not change during the year. The Medicare program does not allow us to *decrease* your benefits during the calendar year. We are allowed to decrease your benefits only on January 1, at the beginning of the next calendar year. The Medicare program must approve any *decreases* we make in your benefits. We will tell you in advance (in October 2007) if there are going to be any increases or decreases in your benefits for the next calendar year that begins on January 1, 2008.

At any time during the year, the Medicare program can change its national coverage. Since we cover what Original Medicare covers, we would have to make any change that the Medicare program makes. These changes could be to increase or decrease your benefits, depending on what change the Medicare program makes. In some cases, if your benefits increase, Original Medicare will pay for the benefit for the rest of the calendar year. In those cases, you will have to pay Original Medicare out-of-pocket amounts for those services. We will let you know in advance if you will have to pay Original Medicare out-of-pocket amounts for an increased benefit.

Can the prescription drugs that we cover change during the year?

The Medicare program allows us to make changes in our prescription drug formulary list at any time during the calendar year. As we explain in Section 6, the formulary is a list of drugs. A change in our drug formulary list could affect which drugs are covered for you and how much you have to pay when you fill a covered prescription.

Section 5 Medical care and services that are NOT covered or are limited (list of exclusions and limitations)

Introduction

The purpose of this section is to tell you about medical care and services that are not covered (“excluded”) or are limited by Tufts Medicare Preferred HMO Prime. The list below tells about these exclusions and limitations. The list describes services that are not covered under *any* conditions, and some services that are covered only under specific conditions. (The Benefits Chart in Section 4 also explains about some restrictions or limitations that apply to certain services).

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If you get services that are not covered, you must pay for them yourself

We will not pay for the exclusions that are listed in this section (or elsewhere in this booklet), and neither will Original Medicare, unless they are found upon appeal to be services that we should have paid or covered (appeals are discussed in Sections 10 and 11).

What services are not covered, or are limited by Tufts Medicare Preferred HMO Prime?

In addition to any exclusions or limitations described in the Benefits Chart in Section 4, or anywhere else in this booklet, **the following items and services are not covered except as indicated by Tufts Medicare Preferred HMO Prime:**

1. Services that are not covered under Original Medicare, *unless* such services are specifically listed as covered in Section 4.
2. Services that you get from non-plan providers, *except* for care for a medical emergency and urgently needed care, renal (kidney) dialysis services that you get when you are temporarily outside the plan’s service area, and care from non-plan providers that is arranged or approved by a plan provider. See other parts of this booklet (especially Sections 2 and 3) for information about using plan providers and the exceptions that apply.
3. Services that you get without a referral from your PCP, when a referral from your PCP is required for getting that service.
4. Services that you get without prior authorization from Tufts Health Plan, when prior authorization is required for getting that service. (Section 4 gives a definition of prior authorization and tells which services require prior authorization.)
5. Services that are not reasonable and necessary according to the standards of original Medicare unless these services are otherwise listed by Tufts Medicare Preferred HMO Prime as a covered service. As noted in Section 4, we provide all covered services according to Medicare guidelines.
6. Emergency facility services for non-authorized, routine conditions that do not appear to a reasonable person to be based on a medical emergency. (See Section 3 for more information about getting care for a medical emergency).

7. Experimental or investigational medical and surgical procedures, equipment and medications, unless covered by Original Medicare or unless for certain services covered under an approved clinical trial. Experimental procedures and items are those items and procedures determined by Tufts Health Plan and Original Medicare to not be generally accepted by the medical community. See Section 7 for information about participation in clinical trials while you are a member of Tufts Medicare Preferred HMO Prime.
8. Surgical treatment of morbid obesity *unless* medically necessary and covered under Original Medicare.
9. Private room in a hospital, *unless* medically necessary.
10. Private duty nurses.
11. Personal convenience items, such as a telephone or television in your room at a hospital or skilled nursing facility.
12. Nursing care on a full-time basis in your home.
13. Custodial care is not covered by Tufts Medicare Preferred HMO Prime *unless* it is provided in conjunction with skilled nursing care and/or skilled rehabilitation services. “Custodial care” includes care that helps people with activities of daily living, like walking, getting in and out of bed, bathing, dressing, eating and using the bathroom, preparation of special diets, and supervision of medication that is usually self-administered.
14. Homemaker services.
15. Charges imposed by immediate relatives or members of your household.
16. Meals delivered to your home.
17. Elective or voluntary enhancement procedures, services, supplies and medications including but not limited to: weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and mental performance unless medically necessary.
18. Cosmetic surgery or procedures, *unless* it is needed because of accidental injury or to improve the function of a malformed part of the body. Breast surgery is covered for all stages of reconstruction for the breast on which a mastectomy was performed and, to produce a symmetrical appearance, surgery and reconstruction of the unaffected breast.
19. Routine dental care (such as cleanings, fillings, or dentures) or other dental services (such as extractions, root canals, or implants). Certain dental services that you get when you are in the hospital will be covered.
20. Chiropractic care is generally not covered under the plan, (with the exception of manual manipulation of the spine to correct a subluxation, as outlined in Section 4) and is limited according to Medicare guidelines. Examples of non-covered chiropractic services provided by a chiropractor include, but are not limited to, x-rays, evaluations, and physical therapy.
21. Routine foot care is generally not covered under the plan and is limited according to Medicare guidelines.
22. Orthopedic shoes, *unless* they are part of a leg brace and are included in the cost of the leg brace. There is an exception: Orthopedic or therapeutic shoes are covered for people with diabetic foot disease (as shown in Section 4, in the Benefits Chart under “Outpatient Medical Services”).

23. Supportive devices for the feet. *There is an exception:* orthopedic or therapeutic shoes are covered for people with diabetic foot disease (as shown in Section 4, in the Benefits Chart under “Outpatient Medical Services”).
24. Radial keratotomy, LASIK surgery, vision therapy and other low vision aids and services.
25. Self-administered prescription medication for the treatment of sexual dysfunction, including erectile dysfunction, impotence, and anorgasmia or hyporgasmia.
26. Reversal of sterilization procedures, sex change operations, and non-prescription contraceptive supplies and devices. (Medically necessary services for infertility are covered according to Original Medicare guidelines.)
27. Acupuncture.
28. Naturopath services.
29. Services provided to veterans in Veteran’s Affairs (VA) facilities. However, in the case of emergency services received at a VA hospital, if the VA cost sharing is more than the cost sharing required under Tufts Medicare Preferred HMO Prime, we will reimburse veterans for the difference. Members are still responsible for the Tufts Medicare Preferred HMO Prime cost sharing amount.
30. Under the standard eyeglasses or contact lenses benefits for post cataract surgery and for Keratoconus, Anisometropia (more than 3.0 diopters) and High myopia (more than 7.0 diopters), the additional cost for any non-standard eyeglasses or contact lenses features including, but not limited to, progressive lenses; deluxe frames; contact lens cleaning solution; tints; anti-reflective coating; U-V lenses or oversize lenses that are not deemed medically necessary by the treating physician. Replacement glasses and lenses are covered post cataract surgery without the insertion of an intraocular lens (IOL).
31. Contact lenses, except as described in Section 4, under Vision Care.
32. Cosmetics, self-administered vitamins, fluoride supplements, diet pills, health and beauty aids, or homeopathic medications, whether or not they require a prescription.
33. Prescriptions written by physicians who do not participate in Tufts Medicare Preferred HMO Prime are not covered except in cases of authorized referral by a participating physician, or in an urgent/emergency care situation.
34. Drugs and devices not approved by the FDA.
35. Ambulance transportation service to a doctor’s office, except when you are in an inpatient covered stay (e.g. a SNF covered stay) and other means of transportation would endanger your health.
36. Air ambulance is covered only in emergency situations.
37. The cost of administering Medicare Part D prescription drugs (except for vaccines).
38. Wheelchair van (chair car) transportation even if provided by an ambulance company.

Section 6 Coverage for Outpatient Prescription Drugs

This section describes your outpatient prescription drug coverage as a member of Tufts Medicare Preferred HMO Prime. We will explain what a formulary is and how to use it, our drug management programs, how much you will pay when you fill a prescription for a covered drug, and what an Explanation of Benefits is and how to get additional copies.

Using plan pharmacies to get your prescription drugs covered by us

What are network pharmacies?

With few exceptions, **you must use network pharmacies to get your prescription drugs covered.**

- **What is a “network pharmacy”?** A network pharmacy is a pharmacy at which you can get your prescription drug benefits. We call them “network pharmacies” because they contract with our pharmacy benefits manager to provide pharmacy services for our plan. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies. You are not required to continue going to the same pharmacy to fill your prescription; you can go to any of our network pharmacies. However, if you switch to a different network pharmacy, you must either have a new prescription written by a physician or have the previous pharmacy transfer the existing prescription to the new pharmacy if any refills remain.
- **What are “covered drugs”?** “Covered drugs” is the general term we use to mean all of the outpatient prescription drugs that are covered by our Plan. Covered drugs are listed in the formulary.

How do I fill a prescription at a network pharmacy?

To fill your prescription, you must show your Plan membership card at one of our network pharmacies. If you do not have your membership card with you when you fill your prescription, you may have to pay the full costs of the prescription (rather than paying just your co-payment). If this happens, you can ask us to reimburse you for our share of the cost by submitting a claim to us. To learn how to submit a paper claim, please refer to the paper claims process described on page 43.

The Provider Directory gives you a list of Plan network pharmacies.

As a member of our Plan we will send you a *Provider Directory*, which gives you a list of our network pharmacies. You can use it to find the network pharmacy closest to you. If you don't have the *Provider Directory*, you can get a copy from Customer Relations. They can also give you the most up-to-date information about changes in this Plan's pharmacy network. In addition, you can find this information on our Web site.

What if a pharmacy is no longer a “network pharmacy”?

Sometimes a pharmacy might leave the plan’s network. If this happens, you will have to get your prescriptions filled at another Plan network pharmacy. Please refer to your Provider Directory or call Customer Relations to find another network pharmacy in your area.

How do I fill a prescription through the Plan’s network mail order pharmacy service?

You can use our network mail order pharmacy to fill prescriptions for what we call “maintenance drugs.” These are drugs that you take on a regular basis, for a chronic or long-term medical condition. When you order prescription drugs through our network mail order pharmacy service, you must order at least a 60-day supply, and no more than a 90-day supply of the drug.

Generally, it takes us 14 days to process your order and ship it to you. However, sometimes your mail order may be delayed. If your order is delayed, please call Customer Relations during business hours and we will allow you to fill a partial supply of the medication at a network retail pharmacy.

You are not required to use our mail order services to get an extended supply of maintenance medications. You can also get an extended supply through some retail network pharmacies.

Specialty pharmacies

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Home Infusion pharmacies

Tufts Medicare Preferred HMO Prime will cover home infusion therapy if:

- Your prescription drug is on our Plan’s formulary or a formulary exception has been granted for your prescription drug,
- Our plan has approved your prescription for home infusion therapy,
- Your prescription is written by an authorized prescriber, and
- You get your home infusion services from a Plan home infusion network pharmacy.

Please refer to your *Provider Directory* to find a home infusion pharmacy provider in your area. For more information, please contact Customer Relations.

Long-term care pharmacies

In some cases, residents of a long-term care facility may access their prescription drugs through the facility’s long-term care pharmacy or another network long-term care pharmacy. Please refer to your *Provider Directory* to find out if your long-term care pharmacy is part of our network. If it is not, or for more information, please contact Customer Relations.

What drugs are covered by this Plan?

What is a formulary?

We have a formulary that lists all drugs that we cover. We will generally cover the drugs listed in our formulary as long as the drug is medically necessary, the prescription is filled at a network pharmacy or

through our network mail order pharmacy service and other coverage rules are followed. For certain prescription drugs, we have additional requirements for coverage or limits on our coverage.

The drugs on the formulary are selected by our Plan with the help of a team of health care providers. We select the prescription therapies believed to be a necessary part of a quality treatment program and both brand-name drugs and generic drugs are included on the formulary. A generic drug has the same active-ingredient formula as the brand-name drug. Generic drugs usually cost less than brand-name drugs and are rated by the Food and Drug Administration (FDA) to be as safe and as effective as brand-name drugs.

Not all drugs are included on the formulary. In some cases, the law prohibits coverage of certain types of drugs. (See “Drug Exclusions,” later in this section, for more information about the types of drugs that cannot be covered under a Medicare Prescription Drug Plan.) In other cases, we have decided not to include a particular drug.

Filling prescriptions outside the network

We have network pharmacies outside of the service area where you can get your drugs covered as a member of our plan. Generally, we only cover drugs filled at an out-of-network pharmacy in limited circumstances when a network pharmacy is not available. Below are some circumstances when we would cover prescriptions filled at an out-of-network pharmacy. **Before you fill your prescription in these situations, call Customer Relations to see if there is a network pharmacy in your area where you can fill your prescription.** If you do go to an out-of-network pharmacy for the reasons listed below, you may have to pay the full cost (rather than paying just your co-payment) when you fill your prescription. You can ask us to reimburse you for our share of the cost by submitting a claim form. You should submit a claim to us if you fill a prescription at an out-of-network pharmacy as any amount you pay will help you qualify for catastrophic coverage (see Catastrophic Coverage later in this section).

Note: If we do pay for the drugs you get at an out-of-network pharmacy, you may still pay more for your drugs than what you would have paid if you went to an in-network pharmacy.

Medical Emergencies

We will cover prescriptions that are filled at an out-of-network pharmacy if the prescriptions are related to care for a medical emergency or urgently needed care. In this situation, you will have to pay the full cost (rather than paying just your co-payment) when you fill the prescription. You can ask us to reimburse you for our share of the cost by submitting a paper claim form.

When you travel or are away from the plan’s service area

If you take a prescription drug on a regular basis and you are going on a trip, be sure to check your supply of the drug before you leave. When possible, take along all the medication you will need. You may be able to order your prescription drugs ahead of time through our network mail order pharmacy service or through a retail network pharmacy.

If you are traveling within the U.S., but outside of the Plan’s service area and you become ill or if you lose or run out of your prescription drugs, we will cover prescriptions that are filled at an out-of-network pharmacy if you follow all other coverage rules identified within this document and a network pharmacy is not available. In this situation, you will have to pay the full cost (rather than paying just your co-payment) when you fill the prescription. You can ask us to reimburse you for our share of the cost by submitting a paper claim form.

Prior to filling your prescriptions at an out-of-network pharmacy, call Customer Relations to find out if there is a network pharmacy in the area where you are traveling. If there are no network pharmacies in that area, Customer Relations may be able to make arrangements for you to get your prescriptions from an out-of-network pharmacy.

Other times you can get your prescription covered if you go to an out-of-network pharmacy

We will cover your prescription at an out-of-network pharmacy if at least one of the following applies:

- If you are unable to get a covered drug in a timely manner within our service area because there are no network pharmacies within a reasonable driving distance that provide 24-hour service
- If you are trying to fill a covered prescription drug that is not regularly stocked at an eligible network retail or mail order pharmacy (these drugs include orphan drugs or other specialty pharmaceuticals).

Before you fill your prescription in either of these situations, call Customer Relations to see if there is a network pharmacy in your area where you can fill your prescription. If you do go to an out-of-network pharmacy for the reasons listed above, you will have to pay the full cost (rather than just paying your co-payment) when you fill your prescription. You can ask us to reimburse you for our share of the cost by submitting a claim form.

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How do I submit a paper claim?

When you go to a network pharmacy, your claim is automatically submitted to us by the pharmacy. However, if you go to an out-of-network pharmacy for one of the reasons listed previously, the pharmacy may not be able to submit the claim directly to us. When that happens, you will have to pay the full cost of your prescription. You may call Customer Relations at the number on the cover of this booklet to obtain a Prescription Reimbursement claim form. Fill out the form and attach your receipt(s). You may wish to keep a copy for your records. Mail the Prescription Reimbursement claim form with your receipt(s) attached to the Pharmacy Claims address on the back of your ID card.

If you submit a paper claim to us, the claim is treated as a request for a coverage determination. If you are asking us to reimburse you for a prescription drug that is not on our formulary or is subject to coverage requirements or limits, your doctor may need to submit additional documentation supporting your request. See Section 12 to learn more about requesting coverage determinations.

How do you find out what drugs are on the formulary?

You may call Customer Relations to find out if your drug is on the formulary or to request a copy of our formulary. You can also get updated information about the drugs covered by us by visiting our Web site.

What are drug tiers?

Drugs on our formulary are organized into different drug tiers, or groups of different drug types. Your co-payment depends on which drug tier your drug is in. The tables on the following pages (under “Initial Coverage Period”) shows the co-payment amount you pay for each tier when you are in your initial coverage period. You can ask us to make an exception (which is a type of coverage determination) to your drug’s tier placement in certain circumstances. (See “Can the formulary change?” on the following page).

Can the formulary change?

We may add or remove drugs from the formulary during the year. Changes in the formulary may affect which drugs are covered and how much you will pay when filling your prescription. If we remove drugs from the formulary, add prior authorizations, quantity limits and/or step therapy restrictions on a drug or move a drug to a higher cost-sharing tier, and you are taking the drug affected by the change, we will notify you of the change at least 60 days before the date that the change becomes effective. If we don't notify you of the change in advance, we will give you a 60-day supply of the drug when you request a refill of the drug. However, if a drug is removed from our formulary because the drug has been recalled from the market, we will not give 60-days notice before removing the drug from the formulary or give you a 60-day supply of the drug when you request a refill. Instead, we will remove the drug from our formulary immediately and notify members about the change as soon as possible.

Immediately after receiving the 60-day notice or 60-day supply, you should work with your physician to either switch to a drug we cover or request an exception (which is a type of coverage determination). If your physician determines that you need the drug that is being removed from our formulary and none of the drugs we cover are medically appropriate for you, you or your physician may request an exception. Similarly, if your physician determines that you are not able to meet a prior authorization, quantity limit, step therapy restriction, or other utilization management requirement for medical necessity reasons, you or your physician may request an exception. (See Section 12 for more information about how to request an exception.).

What if your drug is not on the formulary?

If your prescription is not listed on the formulary, you should first contact Customer Relations to be sure it is not covered.

If Customer Relations confirms that we do not cover your drug, you have three options:

- You can ask your doctor if you can switch to another drug that is covered by us. If you would like to give your doctor a list of covered drugs that are used to treat similar medical conditions, please contact Customer Relations.
- You can ask us to make an exception (which is a type of coverage determination) to cover your drug. (See Section 12 for more information about how to request an exception.).
- You can pay out-of-pocket for the drug and request that the plan reimburse you by requesting an exception (which is a type of coverage determination). If the exception request is not approved the plan is not obligated to reimburse you. If the exception is not approved, you may appeal the plan's denial. (See Section 12 for more information on how to request an exception or appeal.)

If you recently joined this plan, you may be able to get a temporary supply of a drug you were taking when you joined our plan if it is not on our formulary. The next section tells the rules governing obtaining temporary supplies of drugs.

Transition Policy

New members in our plan may be taking drugs that are not on our formulary, or that are subject to certain restrictions, such as prior authorization or step therapy. Members should talk to their doctors to decide if they should switch to an appropriate drug that we cover or request a formulary exception (which is a type of coverage determination) in order to get coverage for the drug. See Section 12 to learn more about

how to request an exception. While these new members might talk to their doctors to determine the right course of action, we may cover the non-formulary drug in certain cases during the first 90 days of new membership.

For each of the drugs that is not on our formulary or that have coverage restrictions or limits, we will cover a temporary 30-day supply (unless the prescription is written for fewer days) when the new member goes to a network pharmacy (and the drug is otherwise a “Part D drug”). After the first 30-day supply, we will not pay for these drugs, even if the new member has been a member of the plan less than 90 days.

If the new member is a resident of a long-term care facility, we will cover a temporary 31-day transition supply (unless you have a prescription written for fewer days). We will cover more than one refill of these drugs for the first 90 days for a new member of our plan. If a new member needs a drug that is not on our formulary or subject to other restrictions, such as step therapy or dosage limits, but the new member is past the first 90 days of new membership in our plan, we will cover a 31-day emergency supply of that drug (unless the prescription is for fewer days) while the new member pursues a formulary exception.

As a current member, if your drug is no longer covered, you may request an exception. Outlined below is the standard exception process by which members may request coverage of non-covered drugs.

1. First, contact your physician’s office to discuss a covered, therapeutically appropriate alternative and obtain a new prescription if necessary.
2. If your physician feels it is **medically necessary** for you to continue to take the non-covered drug, he or she can request an exception to coverage based on review for medical necessity. The request must include clinical information that supports why the drug is medically necessary. Forms are available upon request to both the physician and the member via fax, telephone, email and on the Tufts Health Plan website at www.tuftshealthplan.com.
3. If Tufts Medicare Preferred approves your request to cover a non-covered drug, that drug is subject to a Tier-3 co-payment.

As a current member, if your drug has a dispensing limitation and you require a larger quantity of medication than the dispensing limitation allows, you may request a coverage exception. Outlined below is the exception process by which members may request an exception to a dispensing limitation.

1. Contact your physician’s office.
2. If your physician feels it is **medically necessary** for you to obtain more medication than the dispensing limitation allows, he or she can request an exception to the dispensing limitation based on review for medical necessity. The request must include clinical information that supports why you require a larger amount of medication. Forms are available upon request to both the physician and the member via fax, telephone, email and on the Tufts Health Plan website at www.tuftshealthplan.com.

In either of the above listed situations, if Tufts Medicare Preferred does not approve your physician’s request, you have the right to appeal our decision.

As a current member, if your drug moved to a higher co-payment tier, you can ask us to provide coverage at a lower tier. For instance, if your drug is Tier 3, you can ask us to cover it as Tier 2 instead, provided that it is medically necessary for you to take that Tier 3 medication. This would lower the co-payment

amount you would have to pay for your drug. You may call Customer Relations to ask for a tiering exception. When you request a tiering exception, your physician will be required to submit a statement supporting your request based upon medical necessity. Tufts Medicare Preferred cannot begin processing your tiering exception until we receive the supporting information from your physician. If you request a tiering exception without providing a supporting statement from your physician, we will contact you and/or your physician to request this information. If Tufts Medicare Preferred does not receive the supporting statement within a minimum of 96 hours of your initial request (or within a minimum of 48 hours of an expedited request), we may issue an unfavorable determination. If Tufts Medicare Preferred approves coverage of a non-covered drug, you cannot request a tier exception to change the tier from Tier 3 to Tier 2.

As a current member, if you are in a long term care facility and if you experience an unplanned drug change due to a change in level of care, you can request that we approve a one-time, temporary fill of the non-covered medication to allow you time to discuss a transition plan with your physician. Your physician can also request an exception to coverage for the non-covered drug based on review for medical necessity following the standard exception process outlined previously. The temporary “first fill” will generally be up to a 31-day supply, but may be extended to allow you and your physician time to manage the complexities of multiple medications or when special circumstances warrant. You can request a temporary prescription fill by calling the Tufts Medicare Preferred Customer Relations department.

Please note that our transition policy applies only to those drugs that are “Part D drugs” and that are purchased at a network pharmacy. The transition policy cannot be used to purchase a non-Part D drug or drug out-of-network.

In some cases, we will contact you if you are taking a drug that is not on our formulary. We can give you the names of covered drugs that also are used to treat your condition so you can ask your doctor if any of these drugs are an option for your treatment.

Drug exclusions

By law, certain types of drugs or categories of drugs are not covered by Medicare Prescription Drug Plans. These drugs are not considered Part D drugs and may be referred to as “exclusions” or “non-Part D drugs.” These drugs include:

Nonprescription drugs (except insulin)	Drugs when used for anorexia, weight loss, or weight gain
Drugs when used to promote fertility	Drugs when used for cosmetic purposes or hair growth
Drugs when used for the symptomatic relief of cough or colds	Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
Outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer as a condition of sale	Barbituates and Benzodiazepines

NOTE: Due to a change in Medicare, Tufts Medicare Preferred HMO Prime will no longer cover erectile dysfunction (ED) drugs like Viagra, Cialis, Levitra, and Caverject starting January 1, 2007.

In addition, a Medicare Prescription Drug Plan cannot cover a drug that would be covered under Medicare Part A or Part B. (See “How does your enrollment in this Plan affect coverage for drugs covered under Medicare Part A or Part B?” later.)

Also, while a Medicare Prescription Drug Plan can cover off-label uses of a prescription drug, we cover the off-label use only in cases where the use is supported by certain reference book citations. Congress specifically listed the reference books that list whether the off-label use would be permitted¹. If the use is not supported by one of these reference books (known as compendia), then the drug would be considered a non-Part D drug and would not be covered by our plan.

We offer additional coverage on some prescription drugs not normally covered in a Medicare Prescription Drug Plan. This includes individual drugs that belong to the categories listed previously. The amount you pay when you fill a prescription for these drugs does not count towards qualifying you for catastrophic coverage. In addition, if you are receiving extra help from Medicare to pay for your prescriptions, the extra help will not pay for these drugs. Please refer to your formulary to find out which drugs we are offering additional coverage for or call Customer Relations if you have any questions.

Drug Management Programs

Utilization management

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For certain prescription drugs, we have additional requirements for coverage or limits on our coverage. These requirements and limits ensure that our members use these drugs in the most effective way and also help us control drug plan costs. A team of doctors and pharmacists developed the following requirements and limits for our Plan to help us to provide quality coverage to our members:

Prior Authorization: We require you to get prior authorization for certain drugs. This means that the prescribing physician will need to get approval from us before you fill your prescription. If they don't get approval, we may not cover the drug.

Quantity Limits: For certain drugs, we limit the amount of the drug that we will cover per prescription or for a defined period of time. For example, we will cover up to 9 tablets per prescription for Imitrex.

Generic Substitution: When there is a generic version of a brand-name drug available, our network pharmacies will automatically give you the generic version, unless your doctor has told us that you must take the brand-name drug.

You can find out if the drug you take is subject to these additional requirements or limits by looking in the formulary. If your drug is subject to one of these additional restrictions or limits and your physician determines that you are not able to meet the additional restriction or limit for medical necessity reasons, you or your physician can request an exception (which is a type of coverage determination). (See Section 12 for more information about how to request an exception.).

¹These compendia are : (1) American Hospital Formulary Service Drug Information; United States Pharmacopoeia-Drug Information; and (3) the DRUGDEX Information System.

Drug utilization review

We conduct drug utilization reviews for all of our members to make sure that they are receiving safe and appropriate care. These reviews are especially important for members who have more than one doctor who prescribe their medications. We conduct drug utilization reviews each time you fill a prescription and on a regular basis by reviewing our records. During these reviews, we look for medication problems such as:

- Possible medication errors
- Duplicate drugs that are unnecessary because you are taking another drug to treat the same medical condition
- Drugs that are inappropriate because of your age or gender
- Possible harmful interactions between drugs you are taking
- Drug allergies
- Drug dosage errors

If we identify a medication problem during our drug utilization review, we will work with your doctor to correct the problem.

Medication therapy management programs

We offer medication therapy management programs at no additional cost for members who have multiple medical conditions, who are taking many prescription drugs, or who have high drug costs. These programs were developed for us by a team of pharmacists and doctors. We use these medication therapy management programs to help us provide better coverage for our members. For example, these programs help us make sure that our members are using appropriate drugs to treat their medical conditions and help us identify possible medication errors.

We offer medication therapy management programs for members that meet specific criteria. We may contact members who qualify for these programs. If we contact you, we hope you will join so that we can help you manage your medications. Remember, you do not need to pay anything extra to participate.

If you are selected to join a medication therapy management program, we will send you information about the specific program, including information about how to access the program.

How does your enrollment in this Plan affect coverage for the drugs covered under Medicare Part A or Part B?

Your enrollment in this Plan does not affect Medicare coverage for drugs covered under Medicare Part A or Part B. If you meet Medicare's coverage requirements, your drug will still be covered under Medicare Part A or Part B even though you are enrolled in this Plan. See your *Medicare & You* Handbook for more information about drugs that are covered by Medicare Part A and Part B.

How much do you pay for drugs covered by this Plan?

If you qualify for extra help with your drug costs, your costs for your drugs may be different than those described below. (See “What extra help is available?” later in this section and the “Evidence of Coverage Rider for those who get extra help paying for their prescription drugs” for more information.)

When you fill a prescription for a covered drug, you may pay part of the costs for your drug. The amount you pay for your drug depends on what coverage level you are in (i.e., initial coverage period, after you reach your initial coverage limit, and catastrophic level), the type of drug it is, and whether you are filling your prescription at an in-network or out-of-network pharmacy. Each phase of the benefit and your drug costs for each coverage level is described on the following pages.

Until your annual out-of-pocket costs reach \$3,850, we will pay part of the costs for your covered drugs, and you (or others on your behalf) will pay the other part. The amount you pay when you fill a covered prescription is called the co-payment. Your co-payment will vary depending on the drug and where the prescription is filled.

<i>Drug Tier</i>	<i>Retail Co-payment (up to a 30- day Supply)</i>	<i>Retail Co-payment (up to a 90- day Supply)</i>	<i>Mail-Order Co-payment (up to a 90-day supply)</i>	<i>Out of Network Co-payment (up to a 30-day supply)</i>
Tier 1	\$10	\$30	\$20	\$10
Tier 2	\$25	\$75	\$50	\$25
Tier 3	\$50	\$150	\$100	\$50

* Amounts in this chart may vary according to your individual out-of-network cost sharing responsibility.

In an emergency or urgent care situation, you may purchase a 30-day supply of medication at an out-of-network pharmacy. However, in addition to the applicable retail co-payment you may be responsible for the difference between the medication cost when purchased at a network pharmacy (our contracted price) and the cost when purchased at an out-of-network pharmacy.

Catastrophic Coverage

All Medicare Prescription Drug Plans include catastrophic coverage for people with high drug costs. In order to qualify for catastrophic coverage, you must spend \$3,850 out-of-pocket for the year. When the total amount you have paid toward your co-payments, and the cost for covered Part D drugs after you reach the initial coverage limit reaches \$3,850, you will qualify for catastrophic coverage.

During catastrophic coverage you will pay:

<i>Drug Tier</i>	<i>Retail Co-payment (up to a 30- day Supply)</i>	<i>Retail Co-payment (up to a 90- day Supply)</i>	<i>Mail-Order Co-payment (up to a 90-day supply)</i>	<i>Out of Network Co-payment (up to a 30-day supply)</i>
Tier 1	\$2	\$2	\$2	\$2
Tier 2	\$8	\$8	\$8	\$8
Tier 3	\$14	\$14	\$14	\$14

We will pay the rest.

Note: As mentioned earlier we offer additional coverage on some prescription drugs not normally covered in a Medicare Prescription Drug Plan. The amount you pay when you fill a prescription for these drugs does not count towards your total out of pocket costs (that is, the amount you pay does not help you move through the benefit or qualify for catastrophic coverage).

What extra help is available?

Medicare provides “extra help” to pay prescription drug costs for people who meet specific income and resources limits. Resources include your savings and stocks, but not your home or car. If you qualify, you will get help paying for your Medicare drug plan’s monthly premium, and prescription co-payments.

Do you qualify for extra help?

People with limited income and resources may qualify for extra help one of two ways. The amount of extra help you get will depend on your income and resources.

1. You automatically qualify for extra help and don’t need to apply. If you have full coverage from a state Medicaid program, get help from Medicaid paying your Medicare premiums (belong to a Medicare Savings Program), or get Supplemental Security Income benefits, you automatically qualify for extra help and do not have to apply for it. Medicare mails letters monthly to people who automatically qualify for extra help.
2. You apply and qualify. You may qualify if your yearly income is less than \$14,700 (single) or \$19,800 (married and living with your spouse), and your resources are less than \$11,500 (single) or \$23,000 (married and living with your spouse). Resources include your savings and stocks but not your home or car. If you think you may qualify, call Social Security at 1-800-772-1213, visit www.socialsecurity.gov on the web, or apply at your State Medical Assistance (Medicaid) office. TTY users should call 1-800-325-0778. After you apply, you will get a letter in the mail letting you know if you qualify and what you need to do next.

The income and resource amounts listed on the previous page are for 2006 and will change in 2007. If you live in Alaska or Hawaii, or pay at least half of the living expenses of dependent family members, income limits are higher.

How do my costs change when I qualify for extra help?

The extra help you get from Medicare will help you pay for your Medicare drug plan's monthly premium, and prescription co-payments. The amount of extra help you get is based on your income and resources.

If you qualify for extra help, we will send you by mail an "Evidence of Coverage Rider for those who receive extra help from Medicare for their prescription drugs" that explains your costs as a member of our Plan. If the amount of your extra help changes during the year, we will also mail you an updated "Evidence of Coverage Rider for those who receive extra help from Medicare for their prescription drugs".

How do you get more information?

For more information on who can get extra help with prescription drug costs and how to apply, call the Social Security Administration at 1-800-772-1213, or visit www.socialsecurity.gov on the Web. TTY/TDD users should call 1-800-325-0778.

In addition, you can look at the 2007 *Medicare & You Handbook*, visit www.medicare.gov on the Web, or call 1-800-MEDICARE (1-800-633-4227). TTY/TDD users should call 1-877-486-2048.

If you have any questions about our Plan, please refer to our Customer Relations numbers listed on the cover and in the Benefits at a Glance section. Or, visit our website.

How is your out-of-pocket cost calculated?

What type of prescription drug payments count toward your out-of-pocket costs?

The following types of payments for prescription drugs can count toward your out-of-pocket costs and help you qualify for catastrophic coverage so long as the drug you are paying for is a Part D drug, on the formulary (or if you get a favorable decision on a coverage determination, exception request or appeal), obtained at a network pharmacy (or you have an approved claim from an out-of-network pharmacy); and otherwise meets our coverage requirements:

- Your co-insurance or co-payments

When you have spent a total of \$3,850 for these items, you will reach the catastrophic coverage level. The amount you pay for your monthly premium does not count toward reaching the catastrophic coverage level.

Purchases that will **not** count toward your out-of-pocket costs include:

- Prescription drugs purchased outside the United States and its territories;
- Prescription drugs not covered by the Plan; and
- We offer additional coverage on some prescription drugs not normally covered in a Medicare Prescription Drug Plan. This includes individual drugs that belong to the categories listed

previously. The amount you pay when you fill a prescription for these drugs does not count towards qualifying you for catastrophic coverage). In addition, if you are receiving extra help from Medicare to pay for your prescriptions, the extra help will not pay for these drugs. Please refer to your formulary to find out which drugs we are offering additional coverage for or call Customer Relations if you have any questions.

Who can pay for your prescription drugs, and how do these payments apply to your out-of-pocket costs?

Except for your premium payments, any payments you make for Part D drugs covered by us count toward your out-of-pocket costs and will help you qualify for catastrophic coverage. In addition, when the following individuals or organizations pay your costs for such drugs, these payments will count toward your out-of-pocket costs (and will help you qualify for catastrophic coverage):

- Family members or other individuals;
- Qualified State Pharmacy Assistance Programs (SPAPs);
- Medicare programs that provide extra help with prescription drug coverage; and
- Most charities or charitable organizations. Please note that if the charity is established, run or controlled by your current or former employer or union, the payments usually will not count toward your out-of-pocket costs.

Payments made by the following do **not** count toward your out-of-pocket costs:

- Group Health Plans;
- Insurance Plans and government funded health programs (e.g. TRICARE, the VA, the Indian Health Service); and
- Third party arrangements with a legal obligation to pay for prescription costs (e.g., Workers Compensation).

If you have coverage from a third party such as those listed above that pays a part of or all of your out-of-pocket costs, you must disclose this information to us.

We will be responsible for keeping track of your out-of-pocket cost amount and will let you know when you have qualified for catastrophic coverage. If you or another party on your behalf have purchased drugs outside of our plan benefit, you will be responsible for submitting appropriate documentation of such purchases to us. In addition, every month you purchase covered prescription drugs through us, you will get an Explanation of Benefits that shows your out-of-pocket cost amount to date.

Explanation of Benefits

What is the Explanation of Benefits?

The Explanation of Benefits is a document you will get each month you use your prescription drug coverage. It will tell you the total amount you have spent on your prescription drugs and the total amount we have paid for your drugs. You will get your Explanation of Benefits in the mail each month that you use the benefits provided by us. You will not get an Explanation of Benefits if you don't use any benefits that month.

What information is included in the Explanation of Benefits?

Your Explanation of Benefits will contain the following information:

- A list of prescriptions you filled during the month, as well as the amount paid for each prescription;
- Information about how to request an exception and appeal our coverage decisions;
- A description of changes to the formulary affecting the prescriptions you filled that will occur at least 60 days in the future;
- A summary of your coverage this year, including information about:
 - **Amount Paid For Prescriptions** -the amounts paid that count towards your initial coverage limit.
 - **Total Out-Of-Pocket Costs That Count Towards Catastrophic Coverage** -The total amount you and/or others have spent on prescription drugs that count towards you qualifying for catastrophic coverage. This total includes the amounts spent for your co-payments and co-insurance, and payments made on covered Part D drugs until your out-of-pocket drug costs reach \$3,850. (This amount does not include payments made by your current or former employer/union, another insurance plan or policy, government funded health program or other excluded parties.)

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What should you do if you did not get an Explanation of Benefits or if you wish to request one?

An Explanation of Benefits is also available upon request. To get a copy, please contact Customer Relations.

How does your prescription drug coverage work if you go to a hospital or skilled nursing facility?

If you are admitted to a hospital for a Medicare-covered stay, Medicare Part A will cover the cost of your prescription drugs while you are in the hospital. Once you are released from the hospital, we will cover your prescription drugs as long as all coverage requirements are met (such as the drugs being on our formulary, filled at a network pharmacy, etc.), they are not covered by Medicare Part A or Part B, are part of the formulary and are purchased at one of our network pharmacies. We will also cover your prescription drugs if they are approved under the coverage determination, exceptions, or appeals process.

If you are admitted to a skilled nursing facility for a Medicare-covered stay, after Medicare Part A stops paying for your prescription drug costs, we will cover your prescriptions as long as the drug meets all of our coverage requirements (including the requirement that the skilled nursing facility pharmacy be in our pharmacy network, unless you meet standards for out-of-network care, and that the drug would not otherwise be covered by Medicare Part B coverage). When you enter, live in, or leave a skilled nursing facility you are entitled to a special enrollment period, during which time you will be able to leave this Plan and join a new Medicare Prescription Drug Plan. (Please see Section 13 of this document for more information about leaving this Plan and joining a new Medicare Prescription Drug Plan.)

Section 7 Hospital care, skilled nursing facility care, and other services (this section gives additional information about some of the covered services that are listed in the Benefits Chart in Section 4)

Hospital care

If you need hospital care, we will arrange covered services for you. Covered services are listed in the Benefits Chart in Section 4 under the heading “Inpatient Hospital Care.” We use “hospital” to mean a facility that is certified by the Medicare program and licensed by the state to provide inpatient, outpatient, diagnostic, and therapeutic services. The term “hospital” does not include facilities that mainly provide custodial care (such as convalescent nursing homes or rest homes). By “custodial care,” we mean help with bathing, dressing, using the bathroom, eating, and other activities of daily living.

See Section 14 for definition of Inpatient care.

Hospital benefits are unlimited except for:

- Mental health and substance abuse services provided in a psychiatric hospital. Coverage for inpatient days in a psychiatric hospital is limited to 190 days in your lifetime. (This limit does not apply to inpatient days for psychiatric care in a general hospital.)
- Services received in a rehabilitation hospital or a long-term care hospital certified under Medicare as a short-term acute care hospital. A short-term acute care hospital is one that has an average length of stay greater than 25 days. You are covered 100% up to 90 days per benefit period. You may use your 60-lifetime reserve days to supplement care in rehabilitation or long-term hospitals. Coverage is limited by prior partial or complete use of these days, which may only be used once in a lifetime.

What is a “benefit period” for care in a rehabilitation or long-term care hospital?

Tufts Medicare Preferred HMO Prime uses benefit periods to determine your coverage for services in a rehabilitation or long-term care hospital. A **“benefit period”** begins on the first day you go to a Medicare-covered rehabilitation or long-term care hospital or a skilled nursing facility (SNF). The benefit period ends when you have not been an inpatient at any rehabilitation or long-term care hospital or SNF for 60 days in a row. If you go to a rehabilitation or long-term care hospital (or SNF) after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods you can have. (Later in this section we explain about SNF services).

Please note that after your rehabilitation or long-term care hospital day limits are used up, we will still pay for covered physician services and other medical services. These services are listed in the Benefits Chart in Section 4 under the heading, “Inpatient services (when the hospital or SNF days are not or are no longer covered).” As shown in the Benefits Chart in Section 4, you must pay the inpatient hospital deductible.

What happens if you join or drop out of Tufts Medicare Preferred HMO Prime during a hospital stay?

If you either join or leave Tufts Medicare Preferred HMO Prime during an inpatient hospital stay, special rules apply to your coverage for the stay and to what you owe for this stay. If this situation applies to you, please call Customer Relations at the telephone number on the cover of this booklet. Customer Relations can explain how your services are covered for this stay, and what you owe to providers, if anything, for the periods of your stay when you were and were not a plan member.

What is a “hospitalist”?

Some contracting medical groups utilize a hospitalist. A hospitalist is a physician who specializes in treating inpatients and who may coordinate a patient’s care when he or she is admitted at a contracting hospital. In most cases, if a hospitalist sees you regularly in the hospital, your PCP will not be treating you during your inpatient stay. The hospitalist will update your PCP so that he or she can coordinate your care after you are discharged from the hospital.

Skilled nursing facility care (SNF care)

If you need skilled nursing facility care, we will arrange these services for you. Covered services are listed in the Benefits Chart in Section 4 under the heading “Skilled nursing facility care.” The purpose of this subsection is to tell you more about some rules that apply to your covered services.

A skilled nursing facility is **a place that provides skilled nursing or skilled rehabilitation services**. It can be a separate facility, or part of a hospital or other health care facility. A Skilled Nursing Facility is called a “SNF” for short. The term “skilled nursing facility” does not include places that mainly provide custodial care, such as convalescent nursing homes or rest homes. (By “custodial care,” we mean help with bathing, dressing, using the bathroom, eating, and other activities of daily living.)

What is skilled nursing facility care?

“Skilled nursing facility care” means a level of care ordered by a physician that must be given or supervised by licensed health care professionals. It can be skilled nursing care, or skilled rehabilitation services, or both. Skilled nursing care includes services that require the skills of a licensed nurse to perform or supervise. Skilled rehabilitation services include physical therapy, speech therapy, and occupational therapy. Physical therapy includes exercise to improve the movement and strength of an area of the body, and training on how to use special equipment such as how to use a walker or get in and out of a wheel chair. Speech therapy includes exercise to regain and strengthen speech and/or swallowing skills. Occupational therapy helps you learn how to do usual daily activities such as eating and dressing by yourself.

To be covered, the care you get in a SNF must meet certain requirements

To be covered, you must need daily skilled nursing or skilled rehabilitation care, or both. If you do not need daily skilled care, other arrangements for care would need to be made. Note that medical services and other skilled care will still be covered when you start needing less than daily skilled care in the SNF.

Stays that provide custodial care only are not covered

“Custodial care” is care for personal needs rather than medically necessary needs. Custodial care is care that can be provided by people who do not have professional skills or training. This care includes help with walking, dressing, bathing, eating, preparation of special diets, and taking medication. Custodial care is not covered by Tufts Medicare Preferred HMO Prime unless it is provided as other care you are getting *in addition to* daily skilled nursing care and/or skilled rehabilitation services.

There are benefit period limitations on coverage of skilled nursing facility care

Inpatient skilled nursing facility coverage is limited to 100 days each benefit period. A **“benefit period”** begins on the first day you go to a Medicare-covered inpatient hospital or a SNF. The benefit period ends when you have not been an inpatient at any hospital or SNF for 60 days in a row. If you go to the hospital (or SNF) after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods you can have.

Please note that after your SNF day limits are used up, physician services and other medical services will still be covered. These services are listed in the Benefits Chart in Section 4 under the heading, “Inpatient services (when the hospital or SNF days are not or are no longer covered).”

As shown in the Benefits chart in Section 4, there is no co-payment for covered services received at a Skilled Nursing Facility. Your provider must obtain prior authorization from Tufts Health Plan.

In some situations, you may be able to get care in a SNF that is not a plan provider

Generally, you will get your skilled nursing facility care from SNFs that are plan providers within your PCP’s referral network for Tufts Medicare Preferred HMO Prime. However, *if certain conditions are met*, you may be able to get your skilled nursing facility care from a SNF that is outside of your PCP’s referral network or is not a plan provider. One of the conditions is that the SNF that is not a plan provider must be willing to accept Tufts Health Plan’s rates for payment. At your request, we may be able to arrange for you to get your skilled nursing facility care from one of the facilities listed below (in these situations, the facility is called a “Home SNF”):

- A nursing home or continuing care retirement community where you were living right before you went to the hospital (as long as the place gives skilled nursing facility care).
- A SNF where your spouse is living at the time you leave the hospital.

What happens if you join or drop out of Tufts Medicare Preferred HMO Prime during a SNF stay?

If you either join or leave Tufts Medicare Preferred HMO Prime during a SNF stay, please call Customer Relations at the telephone number on the cover of this booklet. Customer Relations can explain how your services are covered for this stay, and what you owe to Tufts Health Plan, if anything, for the periods of your stay when you were and were not a plan member.

Home health agency care

Home health care is skilled nursing care and certain other health care services that you get in your home for the treatment of an illness or injury. Covered services are listed in the Benefits Chart in Section 4

under the heading “Home health care.” If you need home health care services, we will arrange these services for you if the requirements described on the following page are met.

What are the requirements for getting home health agency services?

To get home health agency care benefits, you must meet all of these conditions:

1. You must be **home-bound**. This means that you are normally unable to leave your home and that leaving home is a major effort. When you leave home, it must be to get medical treatment or be infrequent, for a short time. You may attend religious services. You can also get care in an adult day care program that is licensed or certified by a state or accredited to furnish adult day care services in a state.

Occasional absences from the home for non-medical purposes, such as an occasional trip to the barber or a walk around the block or a drive, would not mean that you are not homebound if the absences are infrequent or are of relatively short duration. The absences cannot indicate that you have the capacity to obtain the health care provided outside of your home.

Generally speaking, you will be considered to be homebound if you have a condition due to an illness or injury that restricts your ability to leave your home except with the aid of supportive devices or if leaving home is medically contraindicated. “Supportive devices” include crutches, canes, wheelchairs, and walkers, the use of special transportation, or the assistance of another person.

2. Your doctor must decide that you need medical care in your home, and must make a plan for your care at home. Your **plan of care** describes the services you need, how often you need them, and what type of health care worker should give you these services.
3. The home health agency caring for you must be approved by the Medicare program.
4. You must need *at least one* of the following types of skilled care:
 - Skilled nursing care on an “intermittent” (not full time) basis. Generally, this means that you must need at least one skilled nursing visit every 60 days and not require daily skilled nursing care for more than 21 days. Skilled nursing care includes services that can only be performed by or under the supervision of a licensed nurse.
 - Physical therapy, which includes exercise to regain movement and strength to an area of the body, and training on how to use special equipment or do daily activities such as how to use a walker or get in and out of a wheel chair or bathtub.
 - Speech therapy, which includes exercise to regain and strengthen speech skills or to treat a swallowing problem.
 - Continuing occupational therapy, which helps you learn how to do usual daily activities by yourself. For example, you might learn new ways to eat or new ways to get dressed.

Home health care can include services from a home health aide, as long as you are also getting skilled care

As long as some qualifying skilled services are *also* included, the home health care you get can include services from a home health aide. A home health aide does not have a nursing license. The home health aide provides services that do not need the skills of a licensed nurse or therapist, such as help with

personal care such as bathing, using the toilet, dressing, or carrying out the prescribed exercises. The services from a home health aide must be part of the home care of your illness or injury, and they are not covered unless you are *also* getting a covered skilled service. Home health services do not include the costs of housekeepers, food service arrangements, or full-time nursing care at home.

What are “part time” and “intermittent” home health care services?

If you meet the requirements given previously for getting covered home health services, you may be eligible for “part time” or “intermittent” skilled nursing services and home health aide services:

- **“Part-time” or “Intermittent”** means your skilled nursing and home health aide services combined total less than 8 hours per day and 35 or fewer hours each week.

Hospice care for people who are terminally ill

“Hospice” is a special way of caring for people who are terminally ill, and for their families. Hospice care is physical care and counseling that is given by a team of people who are part of a Medicare-certified public agency or private company. Depending on the situation, this care may be given in the home, a hospice facility, a hospital, or a nursing home. Care from a hospice is meant to help patients make the most of the last months of life by giving comfort and relief from pain. The focus is on care, not cure.

As a member of Tufts Medicare Preferred HMO Prime, you may receive care from any Medicare-certified hospice. Your doctor can help you arrange for your care in a hospice. If you are interested in using hospice services, you can call Customer Relations at the number on the cover of this booklet to get a list of the Medicare-certified hospice providers in your area or you can call the Regional Home Health Intermediary at Hospice and Palliative Care Federation of Massachusetts at 1-800-962-2973 (in-state calls only) or 1-781-255-7077 (local).

If you enroll in a Medicare-certified hospice, Original Medicare (rather than Tufts Medicare Preferred HMO Prime) pays the hospice for the hospice services you receive. Your hospice doctor can be a plan provider or a non-plan provider. If you choose to enroll in a Medicare-certified hospice, you are still a plan member and continue to get the rest of your care that is unrelated to your terminal condition through Tufts Medicare Preferred HMO Prime. If you use non-plan providers for your routine care, Original Medicare (rather than Tufts Medicare Preferred HMO Prime) will cover your care and you will have to pay Original Medicare out-of-pocket amounts.

The Medicare program has written a booklet about “Medicare Hospice Benefits.” To get a free copy call 1-800-MEDICARE (1-800-633-4227; TTY 1-877-486-2048), which is the national Medicare help line, or visit the Medicare website at www.medicare.gov. Section 1 tells more about how to contact the Medicare program and about the website.

Please **inform us before you start a clinical trial**, so that we may track your health care services. You do not need to get a referral from a plan provider to join a clinical trial. Similarly, the clinical trial providers do not need to be plan providers.

Organ transplants

If you need an organ transplant, we will arrange to have your case reviewed by one of the transplant centers that is approved by Medicare (some hospitals that perform transplants are approved by Medicare,

and others are not). The Medicare-approved transplant center will decide whether you are a candidate for a transplant. When all requirements are met, the following types of transplants are covered: corneal, kidney, pancreas, liver, heart, lung, heart-lung, bone marrow, intestinal/multivisceral, and stem cell. Please be aware that the following transplants are covered only if they are performed in a Medicare-approved transplant center: heart, liver, lung, heart-lung, and intestinal/multivisceral transplants.

Participating in a clinical trial

A “clinical trial” is a way of testing new types of medical care, like how well a new cancer drug works. Clinical trials are one of the final stages of a research process to find better ways to prevent, diagnose, or treat diseases. The trials help doctors and researchers see if a new approach works and if it is safe.

Medicare pays for routine costs if you take part in a clinical trial that meets Medicare requirements. Routine costs include costs like room and board for a hospital stay that Medicare would pay for even if you weren’t in a trial, an operation to implant an item that is being tested, and items and services to treat side effects and complications arising from the new care. Generally, Medicare will not cover the costs of experimental care, such as the drugs or devices being tested in a clinical trial.

There are certain requirements for Medicare coverage of clinical trials. If you participate as a patient in a clinical trial that meets Medicare requirements, Original Medicare (and not Tufts Medicare Preferred HMO Prime) pays the clinical trial doctors and other providers for the covered services you receive that are related to the clinical trial. When you are in a clinical trial, you may stay enrolled in Tufts Medicare Preferred HMO Prime and continue to get the rest of your care that is unrelated to the clinical trial through Tufts Medicare Preferred HMO Prime.

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You will have to pay Original Medicare co-insurance for the services you receive when participating in a qualifying clinical trial. You do not have to pay the Original Medicare Part A or Part B deductibles, because you are enrolled in Tufts Medicare Preferred HMO Prime. For instance, you will be responsible for Part B co-insurance – generally 20% of the Medicare-approved amount for most doctor services and most other outpatient services. However, there is no co-insurance for Medicare-covered clinical laboratory services related to the clinical trial. The Medicare program has written a booklet that includes information on Original Medicare co-insurance rules, called “Medicare & You.” To get a free copy, call 1-800-MEDICARE (1-800-633-4227) or visit www.medicare.gov on the web.

The Medicare program has written a booklet about “Medicare and Clinical Trials.” To get a free copy, call 1-800-MEDICARE (1-800-633-4227) or visit www.medicare.gov on the web. Section 1 tells more about how to contact the Medicare program and about Medicare’s website.

You do *not* need to get a referral from a plan provider to join a clinical trial, and the clinical trial providers do *not* need to be plan providers. However, please be sure to **tell us before you start a clinical trial** so that we can keep track of your health care services. When you tell us about starting a clinical trial, we can let you know what services you will get from clinical trial providers and what your costs for those services will be.

Care in Religious Non-medical Health Care Institutions

Care in a Medicare-certified **R**eligious **N**on-medical **H**ealth **C**are **I**nstitution (RNHCI) is covered by Tufts Medicare Preferred HMO Prime under certain conditions. Covered services in a RNHCI are limited to non-religious aspects of care. To be eligible for covered services in a RNHCI, you must have a medical

condition that would allow you to receive inpatient hospital care or extended care services, or care in a home health agency. You may get services when furnished in the home, but only items and services ordinarily furnished by home health agencies that are not RNHCIs. In addition, you must sign a legal document that says you are conscientiously opposed to the acceptance of “non-excepted” medical treatment. (“Excepted” medical treatment is medical care or treatment that you receive involuntarily or that is required under federal, state or local law. “Non-excepted” medical treatment is any other medical care or treatment.) You must also get authorization (approval) in advance from Tufts Medicare Preferred HMO Prime, or your stay in the RNHCI may not be covered.

Section 8 What you must pay for your Medicare health plan coverage and for the care you receive

Paying the plan premium for your coverage as a member of Tufts Medicare Preferred HMO Prime

To be a member of Tufts Medicare Preferred HMO Prime, you must continue to pay your Medicare Part B premium. If you have to pay a Medicare Part A premium (most people do not), you must continue paying that premium to be a member.

Your employer has a contract with Tufts Medicare Preferred HMO Prime that sets the amount of your plan premium and when and how it must be paid. Your employer may pay your plan premium to Tufts Medicare Preferred for you, or we may bill you and you pay Tufts Medicare Preferred yourself. Check with your benefits administrator.

Tufts Health Plan offers two methods for paying your monthly plan premiums, in addition to direct payment. You can use one of these methods to pay your plan premium. These methods for paying your premiums are called Electronic Fund Transfer (EFT) and Social Security Administration Withhold. If you are interested in either of these methods, or have any questions about your plan premiums, please call Customer Relations at the phone number on the cover of this booklet for more information.

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What happens if you don't pay your plan premiums, or don't pay them on time?

If your plan premiums are past due, we will tell you in writing when a 90-day grace period begins. If you do not pay your past-due plan premiums within the 90-day grace period, we will disenroll you. Disenrolling you ends your membership in Tufts Health Plan. You will then have Original Medicare coverage (Section 12 explains about disenrollment and Original Medicare coverage). Should you decide later to re-enroll in Tufts Medicare Preferred HMO Prime, or to enroll in another plan offered by Tufts Health Plan, you will have to pay any past-due plan premiums that you still owe from your previous enrollment in Tufts Medicare Preferred HMO Prime.

Paying your share of the cost when you get covered services

What are “deductibles,” “co-payments,” and “co-insurance”?

- The “**deductible**” is the amount you must pay for the health care services you receive before Tufts Health Plan begins to pay its share of your covered services. The Benefits Chart in Section 4 gives you the deductible for Inpatient Hospital care.
- A “**co-payment**” is a payment you make for your share of the cost of certain covered services you receive. A co-payment is a **set amount per service** (such as paying \$10 for a doctor visit). You pay it when you get the service. The Benefits Chart in Section 4 gives your co-payments for covered services, including prescription drugs. Section 6 also gives co-payments for prescription drugs.

- **“Co-insurance”** is a payment you make for your share of the cost of certain covered services you receive. Co-insurance is a **percentage of the cost of the service** (such as paying 20% for Medicare-covered immunosuppressive drugs). You pay your co-insurance when you get the service. The Benefits Chart in Section 4 gives your co-insurance for covered services.

You must pay the full cost of services that are not covered

You are personally responsible to pay for care and services that are not covered by Tufts Medicare Preferred HMO Prime. Other sections of this booklet tell about covered services and the rules that apply to getting your care as a plan member. With few exceptions, you must pay for services you receive from providers who are not part of Tufts Medicare Preferred HMO Prime unless Tufts Health Plan has approved these services in advance. The exceptions are care for a medical emergency, urgently needed care, out-of-area renal (kidney) dialysis services, and services that are found upon appeal to be services that we should have paid or covered. (Sections 2 and 3 explain about using plan providers and the exceptions that apply.)

For covered services that have a benefit limitation, **you must pay the full cost of any services you get after you have used up your benefit for that type of covered service.** For example:

- You are covered for 100 days in a SNF during a benefit period. After the 100th day, you must pay the full cost for any additional days during that benefit period.

You can call Customer Relations when you want to know how much of your benefit limit you have already used.

Please keep us up-to-date on any other health insurance coverage you have

Using *all* of your insurance coverage

If you have other health insurance coverage besides Tufts Medicare Preferred HMO Prime, it is important to use this other coverage *in combination with* your coverage as a member to pay for the care you receive. This is called “coordination of benefits” because it involves *coordinating* all of the health *benefits* that are available to you. Using all of the coverage you have helps keep the cost of health care more affordable for everyone.

Let us know if you have additional insurance

You must tell us if you have any other health insurance coverage besides Tufts Medicare Preferred HMO Prime, and let us know whenever there are any *changes* in your additional insurance coverage. The types of additional insurance you might have include the following:

- Coverage that you have from an employer’s group health insurance for *employees* or *retirees*, either through yourself or your spouse.
- Coverage that you have under workers’ compensation because of a job-related illness or injury, or under the Federal Black Lung Program.
- Coverage you have for an accident where no-fault insurance or liability insurance is involved.
- Coverage you have through Medicaid.

- Coverage you have through the “TRICARE for Life” program (veteran’s benefits).
- Coverage you have for dental insurance or prescription drugs.
- “Continuation coverage” that you have through COBRA (COBRA is a law that requires employers with 20 or more employees to let employees and their dependents keep their group health coverage for a time after they leave their group health plan under certain conditions).

Who pays first when you have additional insurance?

How we coordinate your benefits as a member of Tufts Medicare Preferred HMO Prime with your benefits from other insurance depends on your situation. If you have other coverage, you will often get your care as usual through Tufts Medicare Preferred HMO Prime, and the other insurance you have will simply help pay for the care you receive. In other situations, such as for benefits that are not covered by Tufts Medicare Preferred HMO Prime, you may get your care outside of Tufts Medicare Preferred HMO Prime.

The insurance company that pays its share of your bills *first* is called the “**primary payer.**” Then the other company or companies that are involved – called the “**secondary payers**” – each pay their share of what is left of your bills. Often your other insurance company will settle its share of payment directly with us and you will not have to be involved. However, if payment owed to us is sent directly to you, you are required under Medicare law to give this payment to us. When you have additional health insurance, **whether we pay first or second – or at all – depends on what type or types of additional insurance you have and the rules that apply to your situation.** Many of these rules are set by Medicare. Some of them take into account whether you have a disability or have End-Stage Renal Disease (permanent kidney failure), or how many employees are covered by an employer’s group insurance.

If you have additional health insurance, please call Customer Relations at the phone number on the cover of this booklet to find out which rules apply to your situation, and how payment will be handled. Also, the Medicare program has written a booklet with general information about what happens when people with Medicare have additional insurance. It’s called *Medicare and Other Health Benefits: Your Guide to Who Pays First*. You can get a copy by calling 1-800-MEDICARE (1-800-633-4227; TTY 1-877-486-2048), or by visiting the www.medicare.gov website.

What should you do if you have bills from non-plan providers that you think we should pay?

As explained in Sections 2 and 3, we cover certain health care services that you get from non-plan providers. These include care for a medical emergency, urgently needed care, renal dialysis that you get when you are outside the plan’s service area, care that has been approved in advance by Tufts Health Plan, and services that we denied but that were overturned in an appeal. If a non-plan provider asks you to pay for covered services you get in these situations, please contact us at Tufts Medicare Preferred, P.O. Box 9181, Watertown, MA 02471-9181, Attn: Customer Relations department. It is best to ask a non-plan provider to bill us first, but if you have already paid for the covered services we will reimburse you for our share of the cost. If you received a bill for the services, you can send the bill to us for payment. We will pay your doctor for our share of the bill and will let you know what, if anything, you must pay. You will not have to pay a non-plan provider any more than what he or she would have received from you if you had been covered with Original Medicare.

Section 9 Your rights and responsibilities as a member of Tufts Medicare Preferred HMO Prime

Introduction about your rights and protections

Since you have Medicare, you have certain rights to help protect you. In this Section, we explain your Medicare rights and protections as a member of Tufts Medicare Preferred HMO Prime and we explain what you can do if you think you are being treated unfairly or your rights are not being respected. If you want to receive Medicare publications on your rights, you may call and request them at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You can call 24 hours a day, 7 days a week.

Your right to be treated with fairness and respect

You have the right to be treated with dignity, respect, and fairness at all times. Tufts Health Plan must obey laws that protect you from discrimination or unfair treatment. These laws do not allow us to discriminate against you (treat you unfairly) because of your race or color, age, religion, national origin, or any mental or physical disability. If you need help with communication, such as help from a language interpreter, please call Customer Relations at the number on the cover of this booklet. Customer Relations can also help if you need to file a complaint about access (such as wheel chair access). You can also call the Office for Civil Rights at 1-800-368-1019 or TTY/TDD 1-800-537-7697, or, call the Office for Civil Rights in your area.

Your right to the privacy of your medical records and personal health information

There are federal and state laws that protect the privacy of your medical records and personal health information. We protect your personal health information under these laws. Any personal information that you give us when you enroll in this plan is protected. We will make sure that unauthorized people do not see or change your records. Generally, we must get written permission from you (or from someone you have given legal power to make decisions for you) before we can give your health information to anyone who is not providing your care or paying for your care. There are exceptions allowed or required by law, such as release of health information to government agencies that are checking on quality of care.

The laws that protect your privacy give you rights related to getting information and controlling how your health information is used. We are required to provide you with a notice that tells about these rights and explains how we protect the privacy of your health information. For example, you have the right to look at your medical records, and to get a copy of the records (there may be a fee charged for making copies). You also have the right to ask us to make additions or corrections to your medical records (if you ask us to do this, we will review your request and figure out whether the changes are appropriate). You have the right to know how your health information has been given out and used for non-routine

purposes. For more information on how we use and disclose your health information and your rights with respect to your health information, please refer to our *Notice of Privacy Practices* provided in your New Member packet. If you have questions or concerns about privacy of your personal information and medical records, please call Customer Relations at the phone number on the cover of this booklet.

Your right to see plan providers and get covered services within a reasonable period of time

As explained in this booklet, you will get most or all of your care from plan providers, that is, from doctors and other health providers who are part of Tufts Medicare Preferred HMO Prime. You have the right to choose a plan provider (we will tell you which doctors are accepting new patients). You have the right to go to a women's health specialist (such as a gynecologist) without a referral. You have the right to timely access to your providers and to see specialists when care from a specialist is needed. You also have the right to timely access to your prescriptions at any network pharmacy. "Timely access" means that you can get appointments and services within a reasonable amount of time. Section 2 explains how to use plan providers to get the care and services you need. Section 3 explains your rights to get care for a medical emergency and urgently needed care.

Your right to know your treatment choices and participate in decisions about your health care

You have the right to get full information from your providers when you go for medical care, and the right to participate fully in decisions about your health care. Your providers must explain things in a way that you can understand. Your rights include knowing about all of the treatment choices that are recommended for your condition, no matter what they cost or whether they are covered by Tufts Medicare Preferred HMO Prime. This includes the right to know about the different Medication Management Treatment Programs we offer and which you may participate. (See Section 6 for additional information). You have the right to be told about any risks involved in your care. You must be told in advance if any proposed medical care or treatment is part of a research experiment, and be given the choice of refusing experimental treatments.

You have the right to receive a detailed explanation from us if you believe that a plan provider has denied care that you believe you are entitled to receive or care you believe you should continue to receive. In these cases, you must request an initial decision. "Initial decisions" are discussed in Sections 10 and 11.

You have the right to refuse treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to leave. This includes the right to stop taking your medication. If you refuse treatment, you accept responsibility for what happens as a result of refusing treatment.

Your right to use advance directives (such as a living will or a power of attorney)

You have the right to ask someone such as a family member or friend to help you with decisions about your health care. Sometimes, people become unable to make health care decisions for themselves due to accidents or serious illness. If you want to, you can use a special form to give someone you trust the

legal authority to make decisions for you if you ever become unable to make decisions for yourself. You also have the right to give your doctors written instructions about how you want them to handle your medical care if you become unable to make decisions for yourself. The legal documents that you can use to give your directions in advance in these situations are called **“advance directives.”** There are different types of advance directives and different names for them. Documents called **“living will”** and **“power of attorney for health care”** are examples of advance directives.

If you decide that you want to have an advance directive, there are several ways to get this type of legal form. You can get a form from your lawyer, from a social worker, or from some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare, such as SHINE. Section 1 of this booklet tells how to contact SHINE. Regardless of where you get this form, keep in mind that it is a legal document. You should consider having a lawyer help you prepare it. It is important to sign this form and keep a copy at home. You should give a copy of the form to your doctor and to the person you name on the form as the one to make decisions for you if you can't. You may want to give copies to close friends or family members as well.

If you know ahead of time that you are going to be hospitalized, and you have signed an advance directive, take a copy with you to the hospital. If you are admitted to the hospital, they will ask you whether you have signed an advance directive form and whether you have it with you. If you have *not* signed an advance directive form, the hospital has forms available and will ask if you want to sign one.

Remember, it is *your choice* whether you want to fill out an advance directive (including whether you want to sign one if you are in the hospital). According to law, no one can deny you care or discriminate against you based on whether or not you have signed an advance directive. If you *have* signed an advance directive, and you believe that a doctor or hospital has not followed the instructions in it, you may file a complaint with The Department of Public Health, Commissioner's Office, 250 Washington Street, Boston, MA 02110, 1-617-753-8000.

Your right to make complaints

You have the right to make a complaint if you have concerns or problems related to your coverage or care. “Appeals” and “grievances” are the two different types of complaints you can make. The complaint is called an appeal or grievance depending on the situation. Appeals and grievances that involve your Medicare health benefits under Tufts Medicare Preferred HMO Prime are discussed in Sections 10 and 11. Appeals and grievances that involve the prescription drug benefit are discussed in Sections 10 and 12.

If you make a complaint, we must treat you fairly (i.e., not retaliate against you) because you made a complaint. You have the right to get a summary of information about the appeals and grievances that members have filed *against* Tufts Health Plan in the past. To get this information, call Customer Relations at the phone number on the cover of this booklet.

Your right to get information about your health care coverage and costs

This booklet tells you what medical services are covered for you as a plan member and what you have to pay. If you need more information, please call Customer Relations at the number on the cover of this booklet. You have the right to an explanation from us about any bills you may get for services not covered by Tufts Medicare Preferred HMO Prime. We must tell you in writing why we will not pay for

or allow you to get a service, and how you can file an appeal to ask us to change this decision. See Sections 10 and 11 for more information about filing an appeal.

Your right to get information about Tufts Health Plan, Tufts Medicare Preferred HMO Prime, plan providers, your drug coverage, and costs

You have the right to get information from us about Tufts Health Plan and Tufts Medicare Preferred HMO Prime. This includes information about our financial condition, about our health care providers and their qualifications, and about how Tufts Medicare Preferred HMO Prime compares to other health plans. You have the right to find out from us how we pay our doctors. To get any of this information, call Customer Relations at the phone number on the cover of this booklet. You have the right to get information from us about Tufts Medicare Preferred HMO Prime and Part D. This includes information about our financial condition and about our network pharmacies. To get any of this information, call Customer Relations Service at the phone number listed on the cover. Members also have the right to make recommendations regarding members' rights and responsibilities policies.

How to get more information about your rights

If you have questions or concerns about your rights and protections, please call Customer Relations at the number on the cover of this booklet. You can also get free help and information from SHINE (Section 1 tells how to contact SHINE.) In addition, the Medicare program has written a booklet called *Your Medicare Rights and Protections*. To get a free copy, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You can call 24 hours a day, 7 days a week. Or, you can visit www.medicare.gov on the web to order this booklet or print it directly from your computer.

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What can you do if you think you have been treated unfairly or your rights are not being respected?

If you think you have been treated unfairly or your rights have not been respected, what you should do depends on your situation.

- If you think you have been treated unfairly due to your race, color, national origin, disability, age, or religion, please let us know. Or, you can call the Office for Civil Rights in your area at 1-617-565-1340 (TTY/TDD 1-617-565-1343).
- For any other kind of concern or problem related to your Medicare rights and protections described in this section, you can call Customer Relations at the number on the cover of this booklet. You can also get help from SHINE (Section 1 tells how to contact SHINE).

What are your responsibilities as a member of Tufts Medicare Preferred HMO Prime?

Along with the rights you have as a member of Tufts Medicare Preferred HMO Prime, you also have some responsibilities. Your responsibilities include the following:

- To get familiar with your coverage and the rules you must follow to get care as a member. You can use this booklet and other information we give you, such as the *Annual Notice of Change* and

the *Provider Directory* to learn about your coverage, what you have to pay, and the rules you need to follow. Please call Customer Relations at the phone number on the cover of this booklet if you have any questions.

- To give Tufts Medicare Preferred HMO Prime, your doctor and other providers the information they need to care for you, and to follow the treatment plans and instructions that you and your doctors agree upon. Be sure to ask your doctors and other providers if you have any questions and to explain your treatment in a way you understand.
- To act in a way that supports the care given to other patients and helps the smooth running of your doctor's office, hospitals, and other offices.
- To participate with providers in developing mutually agreed upon treatment goals.
- To pay your plan premiums, any co-payments and co-insurance you owe for the covered services you get. You must also meet your other financial responsibilities that are described in Section 8 of this booklet.
- To let us know if you have any questions, concerns, problems, or suggestions. If you do, please call Customer Relations at the phone number on the cover of this booklet.

Section 10 How to file a grievance

What is a Grievance?

A **grievance** is any expression of dissatisfaction you make to Tufts Medicare Preferred HMO Prime, one of our providers or facilities, or MassPRO (the local Quality Improvement Organization). Grievances can be made orally or in writing. A grievance could involve your dissatisfaction with waiting times for appointments or waiting times at your doctor's office, concerns about being treated disrespectfully, or quality of care complaints.

A special grievance process called **"Expedited Grievance"** or **"Fast Grievance"** is available to you if you ask us to expedite either our initial decision to approve or deny a request for services or a reconsideration of an initial decision to deny your request for service authorization and we decide that your request does not require an expedited review. You can file an Expedited Grievance asking us to reconsider our decision not to expedite your request. More information on the Expedited Grievance process is included in Section 11 of this document.

For problems about coverage or payment for care, problems about being discharged from the hospital too soon, and problems about coverage for SNF, HHA, or CORF services ending too soon, you must follow the rules outlined in Section 11.

If you have a problem about our failure to cover or pay for a Part D prescription drug, you must follow the rules outlined in Section 12.

What types of problems might lead to you filing a grievance?

- Problems with the quality of the medical care you receive, including quality of care during a hospital stay.
- If you feel that you are being encouraged to leave (disenroll from) Tufts Medicare Preferred HMO Prime.
- Problems with the Customer Relations service you receive.
- Problems with how long you have to spend waiting on the phone, in the waiting room, in a network pharmacy, or in the exam room.
- Problems with getting appointments when you need them, or having to wait a long time for an appointment.
- Disrespectful or rude behavior by doctors, nurses, receptionists, network pharmacists, or other staff.
- Cleanliness or condition of doctor's offices, clinics, network pharmacies, or hospitals.
- If you disagree with our decision not to expedite your request for an expedited coverage determination, organization determination, redetermination, or reconsideration.
- You believe our notices and other written materials are difficult to understand.
- Failure to give you a decision within the required timeframe.

- Failure to forward your case to the independent review entity if we do not give you a decision within the required timeframe.
- Failure by the Plan to provide required notices.
- Failure to provide required notices that comply with CMS standards.

If you have one of these types of problems and want to make a complaint, it is called “filing a grievance.” In certain cases, you have the right to ask for a “fast grievance,” meaning your grievance will be decided within 24 hours. We discuss these fast grievances in more detail in Section 11 and Section 12.

Filing a grievance with Tufts Health Plan

If you have a complaint, we encourage you to first call Customer Relations at the number on the cover of this booklet. We will try to resolve any complaint that you might have over the phone. If you request a written response to your phone complaint, we will respond in writing to you. **If we cannot resolve your complaint over the phone, we have a formal procedure to review your complaints. We call this our Formal Standard Grievance Process.** Enrollees need to file a grievance either orally or in writing no later than 60 days after the event. They may do so by calling Customer Relations at 1-800-701-9000 (TDD 1-800-208-9562), Monday-Friday, 8:30 A.M. - 5:00 P.M. Enrollees can also file their grievance in writing by sending it by mail to: Tufts Health Plan Medicare Preferred, Attn: Appeals & Grievances Department, 705 Mt. Auburn Street, Watertown, MA 02472. They can also send it in writing via fax at 1-617-972-9431. We must notify you of our decision about your grievance as quickly as your case requires based on your health status, but no later than 30 days after receiving your complaint. We may extend the timeframe by up to 14 days if you request the extension, or if we justify a need for additional information and the delay is in your best interest.

Enrollees also have the right to file an expedited Grievance which could include a complaint that Tufts Health Plan refused to expedite an organization determination or reconsideration, or invoked an extension to an organization determination or reconsideration time frame(s). The time frame for Tufts Health Plan to respond is within 24 hours of your complaint.

For quality of care problems, you may also complain to MassPRO

Complaints concerning the quality of care received under Medicare, including care during a hospital stay, may be acted upon by the plan sponsor under the grievance process, by an independent organization called MassPRO, or by both. For any complaint filed with MassPRO, the plan sponsor must cooperate with MassPRO in resolving the complaint. See Section 1 for more information about MassPRO.

How to file a quality of care complaint with MassPRO

Quality of care complaints filed with MassPRO must be made in writing. An enrollee who files a quality of care grievance with MassPRO is not required to file the grievance within a specific time period. See page 2 of the introduction for more information about how to file a quality of care complaint with MassPRO.

Section 11 Information on how to make a complaint about Part C medical services and benefits

Introduction

This section gives the rules for making complaints about Part C services and payments in different types of situations. **Note: Please see Section 12 for complaints about prescription drugs (Part D).** Federal law guarantees your right to make complaints if you have concerns or problems with any part of your medical care as a plan member. If you make a complaint, we must be fair in how we handle it. You cannot be disenrolled from Tufts Medicare Preferred HMO Prime or penalized in any way if you make a complaint.

Please refer to Original Medicare in Section 8 of your 2007 *Medicare and You Handbook* for additional guidance on your appeal rights under Original Medicare. If you do not have a *Medicare and You Handbook*, please call 1-800 MEDICARE to get a copy.

How to make complaints in different situations

This section tells you how to complain about services or payment in each of the following situations:

- Part 1. Complaints about what benefit or service we will provide you or what we will pay for (cover).**
- Part 2. Complaints if you think you are being discharged from the hospital too soon.**
- Part 3. Complaints if you think your coverage for skilled nursing facility (SNF), home health (HHA) or comprehensive outpatient rehabilitation facility (CORF) services is ending too soon.**

If you want to make a complaint about any type of problem other than those that are listed above, a **grievance** is the type of complaint you would make. **For more information about grievances, including how to file a grievance, see Section 10.**

PART 1. Complaints about what benefit or service Tufts Health Plan will provide you or what Tufts Health Plan will pay for (cover)

What are “complaints about your services or payment for your care?”

If you are not getting the care you want, and you believe that this care is covered by Tufts Medicare Preferred HMO Prime.

- If we will not authorize the medical treatment your doctor or other medical provider wants to give you, and you believe that this treatment is covered by Tufts Medicare Preferred HMO Prime.
- If you are being told that a treatment or service you have been getting will be reduced or stopped, and you believe that this could harm your health.

- If you have received care that you believe should be covered by Tufts Medicare Preferred HMO Prime, but we have refused to pay for this care because we say it is not covered.

What is an organization determination?

An organization determination is our initial decision about whether we will provide the medical care or service you request, or pay for a service you have already received. If our initial decision is to deny your request, you can **appeal** the decision by going on to Appeal Level 1 (see page 78). You may also appeal if we fail to make a timely initial decision on your request.

When we make an “initial decision,” we are giving our interpretation of how the benefits and services that are covered for members of Tufts Medicare Preferred HMO Prime apply to your specific situation. This booklet and any amendments you may receive describe the benefits and services covered by Tufts Medicare Preferred HMO Prime, including any limitations that may apply to these services. This booklet also lists exclusions (services that are “not covered” by Tufts Medicare Preferred HMO Prime).

Who may ask for an “initial decision” about your medical care or payment?

Depending on the situation, your doctor or other medical provider may ask us whether we will authorize the treatment. Otherwise, you can ask us for an initial decision yourself, or you can name (appoint) someone to do it for you. This person you name would be your representative. You can name a relative, friend, advocate, doctor, or someone else to act for you. Some other persons may already be authorized under state law to act for you. If you want someone to act for you, then you and the person you want to act for you must sign and date a statement that gives this person legal permission to act as your representative. This statement must be sent to us at Tufts Medicare Preferred, 705 Mount Auburn Street, Watertown, MA 02472, Attn: Appeals & Grievance Department. You can call us at 1-800-701-9000 (TDD 1-800-208-9562) to learn how to name your representative.

You also have the right to have an attorney ask for an initial decision on your behalf. You can contact your own lawyer, or get the name of a lawyer from your local bar association or other referral service. There are also groups that will give you free legal services if you qualify. You may want to contact:

- Medicare Advocacy Project: 1-800-323-3205
- Insurance, Counseling and Assistance Program: 1-800-882-2003.
- National Medicare Rights Center Appeals Hotline: 1-888-466-9050.

Do you have a request for medical care that needs to be decided more quickly than the standard time frame?

A decision about whether we will cover medical care can be a “standard decision” that is made within the standard time frame (typically within 14 days), or it can be a “fast decision” that is made more quickly (typically within 72 hours). A fast decision is sometimes called an “expedited organization determination.”

You can ask for a fast decision **only** if you or any doctor believe that waiting for a standard decision could seriously harm your health or your ability to function.

Asking for a standard decision

To ask for a standard decision about providing medical care or payment for care, you or your representative should mail or deliver a request in writing to the following address: Tufts Medicare Preferred, 705 Mount Auburn Street, Watertown, MA 02472, Attn: Appeals & Grievance Department.

Asking for a fast decision

You, any doctor, or your representative can ask us to give a “fast” decision (rather than a “standard” decision) about medical care by calling us at 1-800-701-9000 (TDD 1-800-208-9562). Or, you can deliver a written request to Tufts Medicare Preferred, 705 Mount Auburn Street, Watertown, MA 02472, Attn: Appeals & Grievance Department, or fax it to 1-617-673-0300. If you are making a request for a “fast” decision outside of the Plan’s regular business hours, you may call Customer Relations and leave a message or you may fax us at the number above, and an Appeals Analyst will get back to you in a timely manner. Be sure to ask for a “fast” or “72-hour” review.

If **any** doctor asks for a fast decision for you, or supports you in asking for one, and the doctor indicates that waiting for a standard decision could seriously harm your health or your ability to function, we will give you a fast decision.

If you ask for a fast decision without support from a doctor, we will decide if your health requires a fast decision. If we decide that your medical condition does not meet the requirements for a fast decision, we will send you a letter informing you that if you get a doctor’s support for a “fast” decision, we will automatically give you a fast decision. The letter will also tell you how to file a “grievance” if you disagree with our decision to deny your request for a fast review. It will also tell you about your right to ask for a “fast grievance.” If we deny your request for a fast decision, we will give you a standard decision. For more information about grievances, see Section 10.

What happens next when you request an initial decision?

1. *For a decision about payment for care you already received.*

We have 30 days to make a decision after we have received your request. However, if we need more information, we can take up to 30 more days. You will be told in writing if we extend the timeframe for making a decision. If we do not approve your request for payment, we must tell you why, and tell you how you can appeal this decision. If you have not received an answer from us within 60 days of your request, you can **appeal** this decision. (An appeal is also called a “reconsideration.”)

2. *For a standard initial decision about medical care.*

We have 14 days to make a decision after we have received your request. However, we can take up to 14 more days if you request the additional time, or if we need more time to gather information (such as medical records) that may benefit you. If we take additional days, we will notify you in writing. If you believe that we should not take additional days, you can make a specific type of complaint called a “fast grievance” (see Section 10).

If we do not approve your request, we must explain why in writing, and tell you of your right to appeal our decision.

If you have not received an answer from us within 14 days of your request (or by the end of any extended time period), you have the right to appeal.

3. *For a fast initial decision about medical care.*

If you receive a “fast” decision, we will give you our decision about your medical care within 72 hours after you or your doctor ask for it – sooner if your health requires. However, we can take up to 14 more days to make this decision if we find that some information is missing which may benefit you, or if you need more time to prepare for this review. If you believe that we should not take any additional days, you can file a fast grievance.

We will tell you our decision by phone as soon as we make the decision. If we deny any part of your request, we will send you a letter that explains the decision within 3 days of contacting you by phone. If we do not tell you about our decision within 72 hours (or by the end of any extended time period), you have the right to appeal. If we deny your request for a fast decision, you may file a fast grievance.

Appeal Level 1: If we deny any part of your request for coverage or payment of a service, you may ask us to reconsider our decision. This is called an “appeal” or a “request for reconsideration.”

Please call us at 1-800-701-9000 (TDD 1-800-208-9562) if you need help in filing your appeal. We give the request to different people than those who were involved in making the initial decision. This helps ensure that we will give your request a fresh look.

If your appeal concerns a decision we made about authorizing medical care, then you and/or your doctor will first need to decide whether you need a “fast” appeal. The procedures for deciding on a “standard” or a “fast” *appeal* are the same as those described for a “standard” or “fast” *initial decision*.

Getting information to support your appeal

We must gather all the information we need to make a decision about your appeal. If we need your assistance in gathering this information, we will contact you. You have the right to obtain and include additional information as part of your appeal. For example, you may already have documents related to the issue, or you may want to get the doctor’s records or the doctor’s opinion to help support your request. You may need to give the doctor a written request to get information.

You can give us your additional information in any of the following ways:

- In writing, to Tufts Medicare Preferred, 705 Mount Auburn Street, Watertown, MA 02472, Attn: Appeals and Grievance Department.
- By fax, at 1-617-673-0300.
- By telephone – if it is a “fast appeal” – at 1-800-701-9000 (TDD 1-800-208-9562).
- In person, at 705 Mount Auburn Street, Watertown, MA 02472.

You also have the right to ask us for a copy of information regarding your appeal. You can call or write us at 1-800-701-9000 (TDD 1-800-208-9562), Tufts Medicare Preferred, 705 Mount Auburn Street, Watertown, MA 02472, Attn: Appeals and Grievance Department.

How do you file your appeal of the initial decision?

The rules about who may file an appeal are the same as the rules about who may ask for an initial

decision. Follow the instructions under “Who may ask for an ‘initial decision’ about medical care or payment?” However, providers who do not have a contract with Tufts Medicare Preferred must sign a “waiver of payment” statement that says that they will not ask you to pay for the medical service under review, regardless of the outcome of the appeal.

How soon must you file your appeal?

You need to file your appeal within 60 days after we notify you of the initial decision. We can give you more time if you have a good reason for missing the deadline. To file your appeal you can call us at the telephone number on the cover of this booklet or send the appeal to us in writing at Tufts Medicare Preferred, 705 Mount Auburn Street, Watertown, MA 02472, Attn: Appeals and Grievance Department.

What if you want a “fast” appeal?

The rules about asking for a “fast” appeal are the same as the rules about asking for a “fast” initial decision.

How soon must we decide on your appeal?

1. *For a decision about payment for care you already received.*

After we receive your appeal, we have 60 days to make a decision. If we do not decide within 60 days, your appeal *automatically* goes to Appeal Level 2.

2. *For a standard decision about medical care.*

After we receive your appeal, we have up to 30 days to make a decision, but will make it sooner if your health condition requires. However, if you request it, or if we find that some information is missing which can help you, we can take up to 14 more days to make our decision. If we do not tell you our decision within 30 days (or by the end of the extended time period), your request will *automatically* go to Appeal Level 2.

3. *For a fast decision about medical care.*

After we receive your appeal, we have up to 72 hours to make a decision, but will make it sooner if your health requires. However, if you request it, or if we find that some information is missing which can help you, we can take up to 14 more days to make our decision. If we do not tell you our decision within 72 hours (or by the end of the extended time period), your request will *automatically* go to Appeal Level 2.

What happens next if we decide completely in your favor?

1. *For a decision about payment for care you already received.*

We must pay within 60 calendar days of the day we received your request for us to reconsider our initial decision.

2. *For a standard decision about medical care.*

We must authorize or provide you with the care you have asked for no later than 30 days after we received your appeal. If we extend the time needed to decide your appeal, we will authorize or provide your medical care when we make our decision.

3. *For a fast decision about medical care.*

We must authorize or provide you with the care you have asked for within 72 hours of receiving your appeal – or sooner, if your health would be affected by waiting this long. If we extended the time needed to decide your appeal, we will authorize or provide your medical care at the time we make our decision.

What happens next if we deny your appeal?

If we deny any part of your appeal, your appeal *automatically* goes on to Appeal Level 2 where an independent review organization will review your case. This organization contracts with the federal government and is not part of Tufts Health Plan. We will tell you in writing that your appeal has been sent to this organization for review. How quickly we must forward your appeal to the organization depends on the type of appeal:

1. *For a decision about payment for care you already received.*

We must send all the information about your appeal to the independent review organization within 60 days from the date we received your Level 1 appeal.

2. *For a standard decision about medical care.*

We must send all of the information about your appeal to the independent review organization as quickly as your health requires, but no later than 30 days after we received your Level 1 appeal.

3. *For a fast decision about medical care.*

We must send all of the information about your appeal to the independent review organization within 24 hours of our decision.

Appeal Level 2: If we deny any part of your Level 1 appeal, your appeal will automatically be reviewed by a government-contracted independent review organization

At the second level of appeal, your case is given a new review by an outside, independent review organization that has a contract with CMS (Centers for Medicare & Medicaid Services), the government agency that runs the Medicare program. This organization has no connection to us. We will tell you when we have sent your appeal to this organization. You have the right to get a copy from us of your case file that we sent to this organization.

How soon must the independent review organization decide?

1. *For an appeal about payment for care*, the independent review organization has up to 60 days to make a decision.
2. *For a standard appeal about medical care*, the independent review organization has up to 30 days to make a decision. However, it can take up to 14 more days if more information is needed and the extension will benefit you.
3. *For a fast appeal about medical care*, the independent review organization has up to 72 hours to make a decision. However, it can take up to 14 more days if more information is needed and the extension will benefit you.

If the independent review organization decides completely in your favor:

The independent review organization will tell you in writing about its decision and the reasons for it.

1. *For an appeal about payment for care,*

We must pay within 30 days after receiving the decision.

2. *For a standard appeal about medical care,*

We must *authorize* the care you have asked for within 72 hours after receiving notice of the decision, or *provide* the care no later than 14 days after receiving the decision.

3. *For a fast appeal about medical care,*

We must authorize or provide you with the care you have asked for within 72 hours of receiving the decision.

Appeal Level 3: If the organization that reviews your case in Appeal Level 2 does not rule completely in your favor, you may ask for a review by an Administrative Law Judge

You must make a request for review by an Administrative Law Judge in writing within 60 days after the date you were notified of the decision made at Appeal Level 2. The deadline may be extended for good cause. You must send your written request to the ALJ Field Office that is listed in the decision you receive from the independent review organization. The Administrative Law Judge will not review the appeal if the dollar value of the medical care does not meet the minimum requirement provided in the independent review organization's decision. If the dollar value is less than the minimum requirement, you may not appeal any further. During this review, you may present evidence, review the record, and be represented by counsel.

How soon does the Judge make a decision?

The Administrative Law Judge will hear your case, weigh all of the evidence up to this point, and make a decision as soon as possible.

If the Judge decides in your favor

We must pay for, authorize, or provide the service you have asked for within 60 days from the date we receive notice of the decision. We have the right to appeal this decision by asking for a review by the Medicare Appeals Council (Appeal Level 4).

If the Judge rules against you

You have the right to appeal this decision by asking for a review by the Medicare Appeals Council (Appeal Level 4). The letter you get from the Administrative Law Judge will tell you how to request this review.

Appeal Level 4: Your case may be reviewed by the Medicare Appeals Council

This Council will first decide whether to review your case

The Medicare Appeals Council does not review every case it receives. If they decide not to review your case, then either you or Tufts Health Plan may request a review by a Federal Court Judge (Appeal Level 5). The Medicare Appeals Council will issue a written notice advising you of any action taken with respect to your request for review. The notice will tell you how to request a review by a Federal Court Judge.

How soon will the Council make a decision?

If the Medicare Appeals Council reviews your case, they will make their decision as soon as possible.

If the Council decides in your favor

We must pay for, authorize, or provide the medical service you have asked for within 60 days from the date we receive notice of the decision. However, we have the right to appeal this decision by asking a Federal Court Judge to review the case (Appeal Level 5), so long as the dollar value of the contested benefit meets the minimum requirement provided in the Medicare Appeals Council's decision. If the dollar value is less than the minimum requirement, the Council's decision is final.

If the Council decides against you

If the amount involved meets the minimum requirement provided in the Medicare Appeals Council's decision, you or we have the right to continue your appeal by asking a Federal Court Judge to review the case (Appeal Level 5). If the value is less than the minimum requirement, the Council's decision is final and you may not take the appeal any further.

Appeal Level 5: Your case may go to a Federal Court

In order to request judicial review of your case, you must file a civil action in a United States district court. The letter you get from the Medicare Appeals Council in Appeal Level 4 will tell you how to request this review. The Federal Court Judge will first decide whether to review your case.

If the contested amount meets the minimum requirement provided in the Medicare Appeals Council's decision, you or we may ask a Federal Court Judge to review the case.

How soon will the judge make a decision?

The Federal judiciary controls the timing of any decision. The judge's decision is final and you may not take the appeal any further.

PART 2. Complaints (appeals) if you think you are being discharged from the hospital too soon

When you are hospitalized, you have the right to get all the hospital care covered by Tufts Medicare Preferred HMO Prime that is necessary to diagnose and treat your illness or injury. The day you leave the hospital (your “discharge date”) is based on when your stay in the hospital is no longer medically necessary. This part of Section 11 explains what to do if you believe that you are being discharged too soon.

Information you should receive during your hospital stay

When you are admitted to the hospital, someone at the hospital should give you a notice called the *Important Message from Medicare*. This notice explains:

- Your right to get all medically necessary hospital services covered.
- Your right to know about any decisions that the hospital, your doctor, or anyone else makes about your hospital stay and who will pay for it.
- That your doctor or the hospital may arrange for services you will need after you leave the hospital.
- Your right to appeal a discharge decision.

Review of your hospital discharge by the Quality Improvement Organization

If you think that you are being discharged too soon, ask your health plan to give you a notice called the *Notice of Discharge & Medicare Appeal Rights*. This notice will tell you:

- Why you are being discharged.
- The date that we will stop covering your hospital stay (stop paying our share of your hospital costs).
- What you can do if you think you are being discharged too soon.
- Who to contact for help.

You (or your representative) may be asked to sign and date this document to show that you received the notice. Signing the notice does not mean that you agree that you are ready to leave the hospital – it only means that you received the notice. If you do not get the notice after you have said that you think you are being discharged too soon, ask for it immediately.

You have the right by law to ask for a review of your discharge date. As explained in the *Notice of Discharge & Medicare Appeal Rights*, if you act quickly, you can ask an outside agency called the Quality Improvement Organization to review whether your discharge is medically appropriate.

What is the “Quality Improvement Organization”?

QIO stands for Quality Improvement Organization. QIO is a group of doctors and other health care experts paid by the federal government to check on and help improve the care given to Medicare patients. They are not part of Tufts Medicare Preferred HMO Prime or your hospital. There is one QIO in each state. QIOs have different names, depending on which state they are in. In Massachusetts, the QIO is called MassPRO. The doctors and other health experts in MassPRO review certain types of complaints

made by Medicare patients. These include complaints about quality of care and complaints from Medicare patients who think the coverage for their hospital stay is ending too soon. Section 1 tells how to contact MassPRO.

Getting a MassPRO review of your hospital discharge

If you want to have your discharge reviewed, you must quickly contact MassPRO. The *Notice of Discharge & Medicare Appeal Rights* gives the name and telephone number of MassPRO and tells you what you must do.

- You must ask MassPRO for a **“fast review”** of whether you are ready to leave the hospital. This “fast review” is also called an “immediate review.”
- You must be sure that you have made your request to MassPRO **no later than noon** on the first working day after you are given written notice that you are being discharged from the hospital. This deadline is very important. If you meet this deadline, you are allowed to stay in the hospital past your discharge date without paying for it yourself while you wait to get the decision from MassPRO (see below).

If MassPRO reviews your discharge, it will first look at your medical information. Then it will give an opinion about whether it is medically appropriate for you to be discharged on the date that has been set for you. MassPRO will make this decision within one full working day after it has received your request and all of the medical information it needs to make a decision.

What happens if MassPRO decides in your favor?

- If MassPRO agrees with you, we will continue to cover your hospital stay for as long as it is medically necessary.

What happens if MassPRO denies your request?

- If MassPRO decides that your discharge date was medically appropriate, you will not be responsible for paying the hospital charges until noon of the day after MassPRO gives you its decision.

What if you do not ask MassPRO for a review by the deadline?

You still have another option: asking Tufts Medicare Preferred HMO Prime for a “fast appeal” of your discharge

If you do not ask MassPRO for a fast review of your discharge by the deadline, you can ask us for a “fast appeal” of your discharge. How to ask us for a fast appeal is covered in Part 1 of this section.

If you ask us for a fast appeal of your discharge and you stay in the hospital past your discharge date, you may have to pay for the hospital care you receive past your discharge date. Whether you have to pay or not depends on the decision we make.

- If we decide, based on the fast appeal, that you need to stay in the hospital, we will continue to cover your hospital care for as long as it is medically necessary.

- If we decide that you should not have stayed in the hospital beyond your discharge date, we will not cover any hospital care you received after the discharge date (unless the independent review organization overturns our decision).

PART 3. Complaints (appeals) if you think your coverage for SNF, Home Health or Comprehensive Outpatient Rehabilitation Facility Services is ending too soon

When you are a patient in a SNF, Home Health Agency (HHA), or Comprehensive Outpatient Rehabilitation Facility (CORF), you have the right to get all the SNF, HHA or CORF care covered by Tufts Medicare Preferred HMO Prime that is necessary to diagnose and treat your illness or injury. The day we end your SNF, HHA or CORF coverage is based on when your stay is no longer medically necessary. This part explains what to do if you believe that your coverage is ending too soon.

Information you will receive during your SNF, HHA or CORF stay

If we decide to end our coverage for your SNF, HHA, or CORF services, you will get written notice either from us or your provider at least 2 calendar days before your coverage ends. You (or your representative) will be asked to sign and date this document to show that you received the notice. Signing the notice does not mean that you agree that coverage should end – it only means that you received the notice.

How to get a review of your coverage by MassPRO

You have the right by law to ask for an appeal of our termination of your coverage. As will be explained in the notice you get from us or your provider, you can ask MassPRO to do an independent review of whether it is medically appropriate to terminate your coverage.

How soon do you have to ask MassPRO to review your coverage?

If you want to appeal the termination of your coverage, you must quickly contact MassPRO. The written notice you got from us or your provider gives the name and telephone number of MassPRO and tells you what you must do.

- If you get the notice 2 days before your coverage ends, you must make your request **no later than noon** of the day after you get the notice.
- If you get the notice and you have more than 2 days before your coverage ends, you must make your request **no later than noon** of the day before the date that your Medicare coverage ends.

What will happen during the review?

MassPRO will ask for your opinion about why you believe the services should continue. You do not have to prepare anything in writing, but you may do so if you wish. MassPRO will also look at your medical information, talk to your doctor, and review other information that we have given to MassPRO. You and MassPRO will each get a copy of our explanation about why we believe that your services should end.

After reviewing all the information, MassPRO will decide whether it is medically appropriate to terminate your coverage on the date that has been set for you. MassPRO will make this decision within one full day after it receives the information it needs to make a decision.

What happens if MassPRO decides in your favor?

If MassPRO agrees with you, then we will continue to cover your SNF, HHA or CORF services for as long as medically necessary.

What happens if MassPRO denies your request?

If MassPRO decides that our decision to terminate coverage was medically appropriate, you will be responsible for paying the SNF, HHA or CORF charges after the termination date on the advance notice you got from us or your provider. Neither Original Medicare nor Tufts Medicare Preferred HMO Prime will pay for these services. If you stop receiving services on or before the date given on the notice, you can avoid any financial liability.

What if you do not ask MassPRO for a review by the deadline?

You still have another option: asking Tufts Medicare Preferred HMO Prime for a “fast appeal” of your discharge.

If you do not ask MassPRO for a fast appeal of your coverage termination by the deadline, you can ask us for a fast appeal. How to ask us for a fast appeal is covered in Part 1 of this section.

If you ask us for a fast appeal of your termination and you continue getting services from the SNF, HHA, or CORF, you may have to pay for the care you receive past your termination date. Whether you have to pay or not depends on the decision we make.

- If we decide, based on the fast appeal, that you need to continue to get your services covered, we will continue to cover your care for as long as medically necessary.
- If we decide that you should not have continued getting your services covered, we will not cover any care you received after the termination date.

Section 12 What to do if you have complaints about your Part D prescription drug benefits

What to do if you have complaints

We encourage you to let us know right away if you have questions, concerns, or problems related to your prescription drug coverage. Please call Customer Relations at the number on the cover of this booklet.

Please note that Section 12 addresses complaints about your Part D prescription drug benefits only. If you have complaints about your MA benefits, you must follow the rules outlined in Section 11.

This section gives the rules for making complaints in different types of situations. Federal law guarantees your right to make complaints if you have concerns or problems with any part of your care as a plan member. The Medicare program has helped set the rules about what you need to do to make a complaint and what we are required to do when we receive a complaint. If you make a complaint, we must be fair in how we handle it. You cannot be disenrolled from Tufts Medicare Preferred HMO Prime or penalized in any way if you make a complaint.

A complaint will be handled as a grievance, coverage determination, or an appeal, depending on the subject of the complaint.

What is a grievance?

A grievance is any complaint other than one that involves a coverage determination. You would file a grievance if you have any type of problem with Tufts Medicare Preferred HMO Prime or one of our network pharmacies that does not relate to coverage for a prescription drug. For example, you would file a grievance if you have a problem with things such as waiting times when you fill a prescription, the way your network pharmacist or others behave, being able to reach someone by phone or get the information you need, or the cleanliness or condition of a network pharmacy. For more information about grievances, including how to file a grievance, see Section 10.

What is a coverage determination?

Whenever you ask for a Part D prescription drug benefit, the first step is called requesting a coverage determination. If your doctor or pharmacist tells you that a certain prescription drug is not covered, **you must contact us if you want to request a coverage determination.** When we make a coverage determination, we are making a decision whether or not to provide or pay for a Part D drug and what your share of the cost is for the drug. You have the right to ask us for an “exception,” which is a type of coverage determination, if you believe you need a drug that is not on our list of covered drugs (formulary) or believe you should get a drug at a lower co-payment. If you request an exception, your physician must provide a statement to support your request.

For more information about coverage determinations and exceptions, see the section “How to request a coverage determination” below.

What is an appeal?

An appeal is any of the procedures that deal with the review of an unfavorable coverage determination. **You cannot request an appeal if we have not issued a coverage determination.** If we issue an unfavorable coverage determination, you may file an appeal called a “redetermination” if you want us to reconsider and change our decision. If our redetermination decision is unfavorable, you have additional appeal rights. For more information about appeals, see the section “How to request an appeal” on page 93.

How to request a coverage determination

What is the purpose of this section?

This part of Section 12 explains what you can do if you have problems getting the prescription drugs you believe we should provide and you want to request a coverage determination. We use the word “provide” in a general way to include such things as authorizing prescription drugs, paying for prescription drugs, or continuing to provide a Part D prescription drug that you have been getting.

What is a coverage determination?

The coverage determination made by Tufts Medicare Preferred HMO Prime is the starting point for dealing with requests you may have about covering or paying for a Part D prescription drug. If your doctor or pharmacist tells you that a certain prescription drug is not covered you should contact Tufts Medicare Preferred HMO Prime and ask us for a coverage determination. With this decision, we explain whether we will provide the prescription drug you are requesting or pay for a prescription drug you have already received. If we deny your request (this is sometimes called an “adverse coverage determination”), you can “appeal” the decision by going on to Appeal Level 1 (see page 94). If we fail to make a timely coverage determination on your request, it will be automatically forwarded to the independent review entity for review (see Appeal Level 2 on page 96).

The following are examples of coverage determinations:

- You ask us to pay for a prescription drug you have already received. This is a request for a coverage determination about payment. You can call us at 1-800-701-9000 (TDD 1-800-208-9562) to get help in making this request.
- You ask for a Part D drug that is not on your plan sponsor’s list of covered drugs (called a “formulary”). This is a request for a “formulary exception.” You can call us at 1-800-701-9000 (TDD 1-800-208-9562) to ask for this type of decision. **See “What is an exception” on the following page for more information about the exceptions process.**
- You ask for an exception to our utilization management tools - such as prior authorization, dosage limits, or quantity limits. Requesting an exception to a utilization management tool is a type of formulary exception. You can call us at 1-800-701-9000 (TDD 1-800-208-9562) to ask for this type of decision. **See “What is an exception” below for more information about the exceptions process.**
- You ask for a non-preferred Part D drug at the preferred cost-sharing level. This is a request for a “tiering exception.” You can call us at 1-800-701-9000 (TDD 1-800-208-9562) to ask for this type

of decision. See **“What is an exception”** below for more information about the exceptions process.

- You ask us to reimburse you for a drug you bought at an out-of-network pharmacy. In certain circumstances, out-of-network purchases, including drugs provided to you in a physician’s office, will be covered by the plan. See Section 6 for a description of these circumstances. You can call us at 1-800-701-9000 (TDD 1-800-208-9562) to make a request for payment or coverage for drugs provided by an out-of-network pharmacy or in a physician’s office.

When we make a coverage determination, we are giving our interpretation of how the Part D prescription drug benefits that are covered for members of Tufts Medicare Preferred HMO Prime apply to your specific situation. This booklet and any amendments you may receive describe the Part D prescription drug benefits covered by Tufts Medicare Preferred HMO Prime, including any limitations that may apply to these benefits. This booklet also lists exclusions (benefits that are “not covered” by Tufts Medicare Preferred HMO Prime).

What is an exception?

An exception is a type of coverage determination. You can ask us to make an exception to our coverage rules in a number of situations.

- You can ask us to cover your drug even if it is not on our formulary. Excluded drugs cannot be covered by a Part D plan unless coverage is through an enhanced plan.
- You can ask us to waive coverage restrictions or limits on your drug. For example, for certain drugs, we limit the amount of the drug that we will cover. If your drug has a quantity limit, you can ask us to waive the limit and cover more.
- You can ask us to provide a higher level of coverage for your drug. If your drug is contained in our non-preferred tier (Tier 3), you can ask us to cover it at the cost-sharing amount that applies to drugs in the preferred tier (Tier 2) instead. This would lower the co-payment amount you must pay for your drug. Please note, if we grant your request to cover a drug that is not on our formulary, you may not ask us to provide a higher level of coverage for the drug.

Generally, we will only approve your request for an exception if the alternative drugs included on the plan formulary would not be as effective in treating your condition and/or would cause you to have adverse medical effects.

Your physician must submit a statement supporting your exception request. In order to help us make a decision more quickly, you should include supporting medical information from your doctor when you submit your exception request.

If we approve your exception request, our approval is valid for the remainder of the plan year, so long as your doctor continues to prescribe the drug for you and it continues to be safe and effective for treating your condition. If we deny your exception request, you can appeal our decision.

Note: If we approve your exception request for a non-formulary drug, you cannot request an exception to the co-payment or co-insurance amount we require you to pay for the drug.

Who may ask for a coverage determination?

You can ask us for a coverage determination yourself, or your prescribing physician or someone you

name may do it for you. The person you name would be your *appointed representative*. You can name a relative, friend, advocate, doctor, or anyone else to act for you. Some other persons may already be authorized under State law to act for you. If you want someone to act for you, then you and that person must sign and date a statement that gives the person legal permission to act as your appointed representative. This statement must be sent to us at Tufts Medicare Preferred, 705 Mount Auburn Street, Watertown, MA 02472, Attn: Appeals & Grievance Department. You can call us at 1-800-701-9000 (TDD 1-800-208-9562) to learn how to name your appointed representative.

You also have the right to have an attorney ask for a coverage determination on your behalf. You can contact your own lawyer, or get the name of a lawyer from your local bar association or other referral service. There are also groups that will give you free legal services if you qualify.

Asking for a “standard” or “fast” coverage determination

Do you have a request for a Part D prescription drug that needs to be decided more quickly than the standard timeframe?

A decision about whether we will cover a Part D prescription drug can be a “standard” coverage determination that is made within the standard timeframe (typically within 72 hours; see below), or it can be a “fast” coverage determination that is made more quickly (typically within 24 hours; see below). A fast decision is sometimes called an “expedited coverage determination.”

You can ask for a fast decision **only** if you or your doctor believe that waiting for a standard decision could seriously harm your health or your ability to function. (Fast decisions apply only to requests for Part D drugs that you have not received yet. You cannot get a fast decision if you are requesting payment for a Part D drug that you already received.)

Asking for a standard decision

To ask for a standard decision, you, your doctor, or your appointed representative should call us at 1-800-701-9000 (TDD 1-800-208-9562). Or, you can deliver a written request to Tufts Medicare Preferred, 705 Mount Auburn Street, Watertown, MA 02472, Attn: Appeals & Grievance Department, or fax it to 1-617-673-0300. If you are making a request outside of the Plan’s regular business hours (see the cover of this booklet for hours of operation), you may call Customer Relations and leave a message or you may fax us at the number above, and an Appeals Analyst will get back to you as expeditiously as possible, but no later than 7 days from the date the appeal request was received.

Asking for a fast decision

You, your doctor, or your appointed representative can ask us to give a fast decision (rather than a standard decision) by calling us at 1-800-701-9000 (TDD 1-800-208-9562). Or, you can deliver a written request to Tufts Medicare Preferred, 705 Mount Auburn Street, Watertown, MA 02472, Attn: Appeals & Grievance Department, or fax it to 1-617-673-0300. If you are making a request for a “fast” decision outside of the Plan’s regular business hours, you may call Customer Relations and leave a message or you may fax us at the number above, and an Appeals Analyst will get back to you in a timely manner. Be sure to ask for a “fast” or “72-hour” review.

- If your doctor asks for a fast decision for you, or supports you in asking for one, and the doctor indicates that waiting for a standard decision could seriously harm your health or your ability to

function, we will automatically give you a fast decision.

- If you ask for a fast coverage determination without support from a doctor, we will decide if your health requires a fast decision. If we decide that your medical condition does not meet the requirements for a fast coverage determination, we will send you a letter informing you that if you get a doctor's support for a fast review, we will automatically give you a fast decision. The letter will also tell you how to file a "grievance" if you disagree with our decision to deny your request for a fast review. If we deny your request for a fast coverage determination, we will give you our decision within the 72 hour standard timeframe.

What happens when you request a coverage determination?

What happens, including how soon we must decide, depends on the type of decision.

1. For a standard coverage determination about a Part D drug, which includes a request about payment for a Part D drug that you already received.

Generally, we must give you our decision no later than 72 hours after we have received your request, but we will make it sooner if your health condition requires. However, if your request involves a request for an exception (including a formulary exception, tiering exception, or an exception from utilization management rules – such as dosage or quantity limits), we must give you our decision no later than 72 hours after we have received your physician's "supporting statement," which explains why the drug you are asking for is medically necessary. If you are requesting an exception, you should submit your prescribing physician's supporting statement with the request, if possible.

We will give you a decision in writing about the prescription drug you have requested. If we do not approve your request, we must explain why, and tell you of your right to appeal our decision. The section "Appeal Level 1" explains how to file this appeal.

If you have not received an answer from us within 72 hours after receiving your request, your request will automatically go to Appeal Level 2, where an independent organization will review your case.

2. For a fast coverage determination about a Part D drug that you have not received.

If you receive a fast review, we will give you our decision within 24 hours after you or your doctor ask for a fast review – sooner if your health requires. If your request involves a request for an exception, we will give you our decision no later than 24 hours after we have received your physician's "supporting statement," which explains why the non-formulary or non-preferred drug you are asking for is medically necessary.

We will give you a decision in writing about the prescription drug you have requested. If we do not approve your request, we must explain why, and tell you of your right to appeal our decision. The section "Appeal Level 1" explains how to file this appeal.

If we decide you are eligible for a fast review, and you have not received an answer from us within 24 hours after receiving your request, your request will automatically go to Appeal Level 2, where an independent organization will review your case.

If we do not grant your or your physician's request for a fast review, we will give you our decision within the standard 72- hour timeframe discussed previously. If we tell you about our

decision not to provide a fast review by phone, we will send you a letter explaining our decision within three calendar days after we call you. The letter will also tell you how to file a “grievance” if you disagree with our decision to deny your request for a fast review, and will explain that we will automatically give you a fast decision if you get a doctor’s support for a fast review.

What happens if we decide completely in your favor?

If we make a coverage determination that is completely in your favor, what happens next depends on the situation.

- 1. For a standard decision about a Part D drug, which includes a request about payment for a Part D drug that you already received.**

We must authorize or provide the benefit you have requested as quickly as your health requires, but no later than 72 hours after we received the request. If your request involves a request for an exception, we must authorize or provide the benefit no later than 72 hours after we have received your physician’s “supporting statement.” If you are requesting reimbursement for a drug that you already paid for and received, we must send payment to you no later than 30 calendar days after we receive the request.

- 2. For a fast decision about a Part D drug that you have not received.**

We must authorize or provide you with the benefit you have requested no later than 24 hours of receiving your request. If your request involves a request for an exception, we must authorize or provide the benefit no later than 24 hours after we have received your physician’s “supporting statement.”

What happens if we deny your request?

If we deny your request, we will send you a written decision explaining the reason why your request was denied. We may decide *completely* or only *partly* against you. For example, if we deny your request for payment for a Part D drug that you have already received, we may say that we will pay nothing or only part of the amount you requested. If a coverage determination does not give you *all* that you requested, you have the right to appeal the decision. (See Appeal Level 1).

How to request an appeal

This part of Section 12 explains what you can do if you disagree with our coverage determination decision.

What kinds of decisions can be appealed?

If you are unhappy with our coverage determination decision, you can ask for an appeal called a “redetermination.” You can generally appeal our decision not to cover a Part D drug, vaccine, or other Part D benefit. You may also appeal our decision not to reimburse you for a Part D drug that you paid for, if you think we should have reimbursed you more than you received, or if you are asked to pay a different cost-sharing amount than you think you are required to pay for a prescription. Finally, if we deny your exceptions request, you can appeal.

How does the appeals process work?

There are five levels to the appeals process. Here are a few things to keep in mind as you read the description of these steps in the appeals process:

- **Moving from one level to the next.** At each level, your request for Part D prescription drug benefits or payment is considered and a decision is made. The decision may be partly or completely in your favor (giving you some or all of what you have asked for), or it may be completely denied (turned down). If you are unhappy with the decision, there may be another step you can take to get further review of your request. Whether you are able to take the next step may depend on the dollar value of the requested drug or on other factors.
- **Who makes the decision at each level?** You make your request for coverage or payment of a Part D prescription drug directly to us. We review this request and make a coverage determination. If our coverage determination is to deny any part of your request, you can go on to the first level of appeal by asking us to review our coverage determination. If you are still dissatisfied with the outcome, you can ask for further review. If you ask for further review, your appeal is sent outside of Tufts Medicare Preferred HMO Prime, where people who are not connected to us review your case and make the decision. After the first level of appeal, all subsequent levels of appeal will be decided by someone who is connected to the Medicare program or the federal court system. This will help ensure a fair, impartial decision.

Each appeal level is discussed in greater detail below.

Appeal Level 1: If we deny any part of your request in our coverage determination, you may ask us to reconsider our decision. This is called an “appeal” or “request for redetermination.”

Please call us at 1-800-701-9000 (TDD 1-800-208-9562) if you need help with filing your appeal. You may ask us to reconsider our coverage determination, even if only part of our decision is not what you requested. When we receive your request to reconsider the coverage determination, we give the request to people at our organization who were not involved in making the coverage determination. This helps ensure that we will give your request a fresh look.

How you make your appeal depends on whether you are requesting reimbursement for a Part D drug you already received and paid for, or authorization of a Part D benefit (that is, a Part D drug that you have not yet received). If your appeal concerns a decision we made about authorizing a Part D benefit that you have not received yet, then you and/or your doctor will first need to decide whether you need a fast appeal. The procedures for deciding on a standard or a fast *appeal* are the same as those described for a standard or fast *coverage determination*. Please see the discussion under “Do you have a request for a Part D prescription drug that needs to be decided more quickly than the standard timeframe?” and “Asking for a fast decision.”

Getting information to support your appeal

We must gather all the information we need to make a decision about your appeal. If we need your assistance in gathering this information, we will contact you. You have the right to obtain and include additional information as part of your appeal. For example, you may already have documents related to

your request, or you may want to get your doctor's records or opinion to help support your request. You may need to give the doctor a written request to get information.

You can give us your additional information in any of the following ways:

- In writing, to Tufts Medicare Preferred, 705 Mount Auburn Street, Watertown, MA 02472, Attn: Appeals & Grievance Department.
- By fax, at 1-617-673-0300
- By telephone – if it is a fast appeal – at 1-800-701-9000 (TDD 1-800-208-9562)
- In person, at 705 Mount Auburn Street, Watertown, MA 02472.

You also have the right to ask us for a copy of information regarding your appeal. You can call or write us at 1-800-701-9000 (TDD 1-800-208-9562), Tufts Medicare Preferred, 705 Mount Auburn Street, Watertown, MA 02472, Attn: Appeals & Grievance Department.

Who may file your appeal of the coverage determination?

The rules about who may file an appeal are almost the same as the rules about who may ask for a coverage determination. For a standard request, you or your appointed representative may file the request. A fast appeal may be filed by you, your appointed representative, or your prescribing physician.

How soon must you file your appeal?

You need to file your appeal within 60 calendar days from the date included on the notice of our coverage determination. We can give you more time if you have a good reason for missing the deadline.

To file a standard appeal, you can send the appeal to us in writing at Tufts Medicare Preferred HMO Prime, 705 Mount Auburn Street, Watertown, MA 02472, Attn: Appeals & Grievance Department.

What if you want a fast appeal?

The rules about asking for a fast appeal are the same as the rules about asking for a fast coverage determination. You, your doctor, or your appointed representative can ask us to give a fast appeal (rather than a standard appeal) by calling us at 1-800-701-9000 (TDD 1-800-208-9562). Or, you can deliver a written request to Tufts Medicare Preferred, 705 Mount Auburn Street, Watertown, MA 02472, or fax it to 1-617-673-0300. If you are making a request for a “fast” decision outside of the Plan’s regular business hours, you may call Customer Relations and leave a message or you may fax us at the number above, and an Appeals Analyst will get back to you in a timely manner. Be sure to ask for a “fast,” “expedited,” or “72-hour” review. Remember, that if your prescribing physician provides a written or oral supporting statement explaining that you need the fast appeal, we will automatically treat you as eligible for a fast appeal.

How soon must we decide on your appeal?

How quickly we decide on your appeal depends on the type of appeal:

1. **For a standard decision about a Part D drug, which includes a request for reimbursement for a Part D drug you already paid for and received.**

After we receive your appeal, we have up to 7 calendar days to give you a decision, but will make

it sooner if your health condition requires us to. If we do not give you our decision within 7 calendar days, your request will automatically go to the second level of appeal, where an independent organization will review your case.

2. For a fast decision about a Part D drug that you have not received.

After we receive your appeal, we have up to 72 hours to give you a decision, but will make it sooner if your health requires us to. If we do not give you our decision within 72 hours, your request will automatically go to Appeal Level 2, where an independent organization will review your case.

What happens next if we decide completely in your favor?

1. For a decision about reimbursement for a Part D drug you already paid for and received.

We must send payment to you no later than 30 calendar days after we receive your request to reconsider our coverage determination.

2. For a standard decision about a Part D drug you have not received.

We must authorize or provide you with the Part D drug you have asked for as quickly as your health requires, but no later than 7 calendar days after we received your appeal.

3. For a fast decision about a Part D drug you have not received.

We must authorize or provide you with the Part D drug you have asked for as quickly as your health requires, but no later than 72 hours after we received your appeal.

What happens next if we deny your appeal?

If we deny any part of your appeal, you or your appointed representative have the right to ask an independent organization to review your case. This independent review organization contracts with the federal government and is not part of Tufts Medicare Preferred HMO Prime.

Appeal Level 2: If we deny any part of your first appeal, you may ask for a review by a government-contracted independent review organization

What independent review organization does this review?

At the second level of appeal, your appeal is reviewed by an outside, independent review organization that has a contract with the Centers for Medicare & Medicaid Services (CMS), the government agency that runs the Medicare program. The independent review organization has no connection to us. You have the right to ask us for a copy of your case file that we sent to this organization.

How soon must you file your appeal?

You or your appointed representative must make a request for review by the independent review organization in writing within 60 calendar days after the date you were notified of the decision on your first appeal. You must send your written request to the independent review organization whose name and address is included in the redetermination notice you receive from Tufts Medicare Preferred HMO Prime.

What if you want a fast appeal?

The rules about asking for a fast appeal are the same as the rules about asking for a fast coverage determination, except your prescribing physician cannot file the request for you – only you or your appointed representative may file the request. If you want to ask for a fast appeal, please follow the instructions under “Asking for a fast decision.” Remember, if your prescribing physician provides a written or oral statement supporting your request for a fast appeal, the IRE will automatically treat you as eligible for a fast appeal.

How soon must the independent review organization decide?

After the independent review organization receives your appeal, how long the organization can take to make a decision depends on the type of appeal:

1. For a standard request about a Part D drug, which includes a request about reimbursement for a Part D drug that you already paid for and received, the independent review organization has up to 7 calendar days from the date it received your request to give you a decision.
2. For a fast decision about a Part D drug that you have not received, the independent review organization has up to 72 hours from the time it receives the request to give you a decision.

If the independent review organization decides completely in your favor:

The independent review organization will tell you in writing about its decision and the reasons for it. What happens next depends on the type of appeal:

1. **For a decision about reimbursement for a Part D drug you already paid for and received.**
We must pay within 30 calendar days from the date we receive notice reversing our coverage determination. We will also send the independent review organization a notice that we have given effect to their decision.
2. **For a standard decision about a Part D drug you have not received.**
We must authorize or provide you with the Part D drug you have asked for within 72 hours from the date we receive notice reversing our coverage determination. We will also send the independent review organization a notice that we have given effect to their decision.
3. **For a fast decision about a Part D drug you have not received.**
We must authorize or provide you with the Part D drug you have asked for within 24 hours from the date we receive notice reversing our coverage determination. We will also send the independent review organization a notice that we have given effect to their decision.

What happens next if the review organization decides against you (either partly or completely)?

The independent review organization will tell you in writing about its decision and the reasons for it. You or your appointed representative may continue your appeal by asking for a review by an Administrative Law Judge (see Appeal Level 3), so long as the dollar value of the contested Part D benefit meets the minimum requirement provided in the independent review organization’s decision.

Appeal Level 3: If the organization that reviews your case in Appeal Level 2 does not rule completely in your favor, you may ask for a review by an Administrative Law Judge

As stated previously, if the independent review organization does not rule completely in your favor, you or your appointed representative may ask for a review by an Administrative Law Judge. You must make a request for review by an Administrative Law Judge in writing within 60 calendar days after the date of the decision made at Appeal Level 2. You may request that the Administrative Law Judge extend this deadline for good cause. You must send your written request to the office specified in the independent review organization's reconsideration notice.

During the Administrative Law Judge review, you may present evidence, review the record (by either receiving a copy of the file or accessing the file in person when feasible), and be represented by counsel. The Administrative Law Judge will not review your appeal if the dollar value of the requested Part D benefit does not meet the minimum requirement provided in the independent review organization's decision. If the dollar value is less than the minimum requirement, you may not appeal any further.

How is the dollar value (the “amount remaining in controversy”) calculated?

If we have refused to provide Part D prescription drug benefits, the dollar value for requesting an Administrative Law Judge hearing is based on the projected value of those benefits. The projected value includes any costs you could incur based on what you would be charged for the drug and the number of refills prescribed for the requested drug during the plan year. Projected value includes your co-payments, all expenditures incurred after your expenditures exceed the initial coverage limit, and expenditures paid by other entities.

You may also combine multiple Part D claims to meet the dollar value if:

1. The claims involve the delivery of Part D prescription drugs to you;
2. All of the claims have received a determination by the independent review organization as described in Appeal Level 2;
3. Each of the combined requests for review are filed in writing within 60 calendar days after the date that each decision was made at Appeal Level 2; and
4. Your hearing request identifies all of the claims to be heard by the Administrative Law Judge.

How soon does the Judge make a decision?

The Administrative Law Judge will hear your case, weigh all of the evidence up to this point, and make a decision as soon as possible.

If the Judge decides in your favor:

The Administrative Law Judge will tell you in writing about his or her decision and the reasons for it. What happens next depends on the type of appeal:

1. *For a decision about payment for a Part D drug you already received.*

We must send payment to you no later than 30 calendar days from the date we receive notice reversing our coverage determination.

2. *For a standard decision about a Part D drug you have not received.*

We must authorize or provide you with the Part D drug you have asked for within 72 hours from the date we receive notice reversing our coverage determination.

3. *For a fast decision about a Part D drug you have not received.*

We must authorize or provide you with the Part D drug you have asked for within 24 hours from the date we receive notice reversing our coverage determination.

If the Judge rules against you:

You have the right to appeal this decision by asking for a review by the Medicare Appeals Council (Appeal Level 4). The letter you get from the Administrative Law Judge will tell you how to request this review.

Appeal Level 4: Your case may be reviewed by the Medicare Appeals Council

The Medicare Appeals Council will first decide whether to review your case. There is no minimum dollar value for the Medicare Appeals Council to hear your case. If you got a denial at Appeal Level 3, you or your appointed representative can request review by filing a written request with the Council.

The Medicare Appeals Council does not review every case it receives. If they decide not to review your case, then you may request a review by a Federal Court Judge (see Appeal Level 5). The Medicare Appeals Council will issue a written notice advising you of any action taken with respect to your request for review. The notice will tell you how to request a review by a Federal Court Judge.

How soon will the Council make a decision?

If the Medicare Appeals Council reviews your case, they will make their decision as soon as possible.

If the Council decides in your favor:

The Medicare Appeals Council will tell you in writing about its decision and the reasons for it. What happens next depends on the type of appeal:

1. *For a decision about payment for a Part D drug you already received.*

We must send payment to you no later than 30 calendar days from the date we receive notice reversing our coverage determination.

2. *For a standard decision about a Part D drug you have not received.*

We must authorize or provide you with the Part D drug you have asked for within 72 hours from the date we receive notice reversing our coverage determination.

3. *For a fast decision about a Part D drug you have not received.*

We must authorize or provide you with the Part D drug you have asked for within 24 hours from the date we receive notice reversing our coverage determination.

If the Council decides against you:

If the amount involved meets the minimum requirement provided in the Medicare Appeals Council's decision, you have the right to continue your appeal by asking a Federal Court Judge to review the case (Appeal Level 5). The letter you get from the Medicare Appeals Council will tell you how to request this review. If the value is less than the minimum requirement, the Council's decision is final and you may not take the appeal any further.

Appeal Level 5: Your case may go to a Federal Court

In order to request judicial review of your case, you must file a civil action in a United States district court. The letter you get from the Medicare Appeals Council in Appeal Level 4 will tell you how to request this review. The Federal Court Judge will first decide whether to review your case.

If the contested amount meets the minimum requirement provided in the Medicare Appeals Council's decision, you may ask a Federal Court Judge to review the case.

How soon will the Judge make a decision?

The Federal judiciary is in control of the timing of any decision.

If the Judge decides in your favor:

Once we receive notice of a judicial decision in your favor, what happens next depends on the type of appeal:

1. *For a decision about payment for a Part D drug you already received.*

We must send payment to you within 30 calendar days from the date we receive notice reversing our coverage determination.

2. *For a standard decision about a Part D drug you have not received.*

We must authorize or provide you with the Part D drug you have asked for within 72 hours from the date we receive notice reversing our coverage determination.

3. *For a fast decision about a Part D drug you have not received.*

We must authorize or provide you with the Part D drug you have asked for within 24 hours from the date we receive notice reversing our coverage determination.

If the Judge decides against you:

The Judge's decision is final and you may not take the appeal any further.

Section 13 Leaving Tufts Medicare Preferred HMO Prime and your choices for continuing Medicare after you leave

Note: Before making any changes, be sure to contact your benefits administrator.

What is “disenrollment”?

“Disenrollment” from Tufts Medicare Preferred HMO Prime means **ending your membership** in Tufts Medicare Preferred HMO Prime. Disenrollment can be **voluntary** (your own choice) or **involuntary** (not your own choice):

- You might leave Tufts Medicare Preferred HMO Prime because you have decided that you *want* to leave. You can do this for any reason. However, as we explain in this section, **there are limits to when you may leave and how often you can make changes, what your other choices are for receiving Medicare services, and how you can make changes.**
- There are also a few situations where you would be *required* to leave. For example, you would have to leave Tufts Medicare Preferred HMO Prime if you move permanently out of our geographic service area or if Tufts Medicare Preferred HMO Prime leaves the Medicare program. We are not allowed to ask you to leave the plan because of your health.

Whether leaving the plan is your choice or not, this section explains your Medicare coverage choices after you leave and the rules that apply.

Until your membership ends, you must keep getting your Medicare services through Tufts Medicare Preferred HMO Prime or you will have to pay for them yourself.

If you leave Tufts Medicare Preferred HMO Prime, it may take some time for your membership to end and your new way of getting Medicare to take effect (we discuss when the change takes effect later in this section). While you are waiting for your membership to end, you are still a member and must continue to get your care as usual through Tufts Medicare Preferred HMO Prime.

If you get services from doctors or other medical providers who are **not** plan providers before your membership in Tufts Medicare Preferred HMO Prime ends, neither Tufts Health Plan nor the Medicare program will pay for these services, with just a few exceptions. The exceptions are urgently needed care, care for a medical emergency, out-of-area renal (kidney) dialysis services, and care that has been approved by us. There is another possible exception, if you happen to be hospitalized on the day your membership ends. If this happens to you, call Customer Relations at the number on the cover of this booklet to find out if your hospital care will be covered by Tufts Medicare Preferred HMO Prime. **If you have any questions about leaving Tufts Medicare Preferred HMO Prime, please call Customer Relations or contact your benefits administrator.**

What should I do if I decide to leave Tufts Medicare Preferred HMO Prime?

If you want to leave Tufts Medicare Preferred HMO Prime,

- What you must do depends on whether you want to switch to Original Medicare or to one of your other choices. Your former employer may require that you make changes during a specific enrollment period. Call your benefits administrator for you options.

When and how often can I change my Medicare choices?

There are limits to when and how often Medicare beneficiaries can change the way they get Medicare coverage. However, as a member of an employer-sponsored health plan, you are covered under the eligibility and enrollment rules established by your former employer. Please check with your benefits administrator for details. If you lose your employer-sponsored Tufts Medicare Preferred HMO Prime plan, you may join Tufts Medicare Preferred HMO Prime as an individual.

NOTE: Remember to always contact your benefits administrator before making a change.

What are my choices, and how do I make changes, if I leave Tufts Medicare Preferred HMO Prime?

If you leave Tufts Medicare Preferred HMO Prime, you have a number of choices for how you receive your Medicare after you leave. If they are available in your area, and if they are accepting new members, you can switch to any of the following types of plans:

- **Other Medicare Advantage Plans** (including HMOs such as Tufts Medicare Preferred HMO Prime, PPOs, and Private Fee-for-service plans) are available in some parts of the country. In HMOs and PPOs, you generally get all your Medicare-covered Part A and Part B health care through the plan. Medicare Advantage Plans *may include prescription drug coverage* as part of the Medicare Prescription Drug (Part D) benefit. Medicare pays a set amount of money for your care every month to these private health plans whether or not you use services. Tufts Medicare Preferred HMO Prime is a Medicare Advantage Plan offered by Tufts Health Plan.
- **Original Medicare** is available throughout the country. Original Medicare is a fee-for-service health plan that lets you go to any doctor, hospital, or other health care provider who accepts Medicare. You must pay a deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share (coinsurance). Original Medicare has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance).
- **Medicare Prescription Drug Plans** (PDPs) are stand-alone drug plans that only cover prescription drugs, not other benefits or services. If you choose Original Medicare and want to receive Medicare prescription drug coverage, you must join a Medicare Prescription Drug Plan.
- **Other Medicare Health Plans** (including Medicare Cost Plans, Programs of All-Inclusive Care for the Elderly (PACE), and Demonstrations) may be available. In some of these plans, you generally get all your Medicare-covered health care from that plan. This coverage *may include prescription drug coverage*.

Note: For more information about your choices, please refer to the “Medicare & You” handbook you received in the fall. You may also call 1-800-MEDICARE (1-800-633-4227), or visit www.medicare.gov to learn more about your choices.

How do I switch from Tufts Medicare Preferred HMO Prime to another Medicare Advantage Plan or Other Medicare Health Plan?

If you want to change from Tufts Medicare Preferred HMO Prime to a different Medicare Advantage Plan or Other Medicare Health Plan, here is what to do:

1. Contact the new plan you want to join to be sure it is accepting new members. Also ask the plan if it offers the Medicare Part D prescription drug benefit.
2. Your new plan will tell you the date when your membership in that plan begins, and your membership in Tufts Medicare Preferred HMO Prime will end on that same day (this will be your “disenrollment date”). Remember, you are still a member until your disenrollment date, and must continue to get your medical care as usual through Tufts Medicare Preferred HMO Prime until the date your membership ends.
3. If you switch to another Medicare Health Plan that is not a Medicare Advantage Plan, and you’ve received confirmation of membership in that plan, we strongly encourage you to notify us or Medicare in order to be disenrolled from Tufts Medicare Preferred HMO Prime.

What if I want to switch (disenroll) from Tufts Medicare Preferred HMO Prime to Original Medicare?

Original Medicare does not cover very many prescription drugs outside of a hospital. So, if you want to change from Tufts Medicare Preferred HMO Prime to Original Medicare, you should think about whether you want to also join a Medicare Prescription Drug Plan.

To get information about Prescription Drug Plans that you can join, you can call 1-800-MEDICARE (1-800-633-4227), which is the national Medicare help line. TTY Users should call 1-877-486-2048. You can call 24 hours a day, 7 days a week.

- If you want Original Medicare *and* Medicare prescription drug coverage, simply enroll in a stand-alone Medicare Prescription Drug Plan (PDP). That will automatically disenroll you from Tufts Medicare Preferred HMO Prime.
- If you want Original Medicare and do *not* want Medicare prescription drug coverage, simply tell us or Medicare that you want to leave Tufts Medicare Preferred HMO Prime. You do *not* have to enroll in Original Medicare, because you will automatically be in Original Medicare when you leave Tufts Medicare Preferred HMO Prime.
- **To tell us** that you want to leave Tufts Medicare Preferred HMO Prime, you can write or fax a letter to us or fill out a disenrollment form and send it to Enrollment at 705 Mount Auburn Street, mail stop 69, Watertown, MA 02472, Attn: Enrollment Department or to our fax number at 617-972-9413. Be sure to sign and date your letter / disenrollment form. To get a disenrollment form, call us at the Customer Relations telephone number on the cover of this booklet.
- **To tell Medicare** you want to leave Tufts Medicare Preferred HMO Prime, you can call 1-800-MEDICARE (1-800-633-4227), which is the national Medicare help line. TTY Users should call 1-877-486-2048. You can call 24 hours a day, 7 days a week.

Whether you tell us or Medicare that you want to leave Tufts Medicare Preferred HMO Prime, you will receive a letter telling you when your membership will end. This is your **disenrollment date** – the day you officially leave Tufts Medicare Preferred HMO Prime. Remember, until your disenrollment date, you are still a member of Tufts Medicare Preferred HMO Prime and must continue to get your medical care as usual through Tufts Medicare Preferred HMO Prime.

Effective on your disenrollment date, your membership in Tufts Medicare Preferred HMO Prime ends and you should use your red, white, and blue Medicare card to get services under Original Medicare. You will not get anything in writing that tells you that you have Original Medicare, because you will *automatically* be in Original Medicare when you leave Tufts Medicare Preferred HMO Prime. (Call Social Security at 1-800-772-1213 if you need a new red, white, and blue Medicare card.)

Do I need to buy a Medigap (Medicare supplement insurance) policy?

If you want to change from Tufts Medicare Preferred HMO Prime to Original Medicare, you should think about whether you want to buy a Medigap policy to supplement your Original Medicare coverage. For Medigap advice, you should contact SHINE (the phone number is in Section 1). You can ask SHINE about how and when to buy a Medigap policy if you need one. SHINE can tell you if you have a guaranteed right to buy a Medigap policy.

If you are at least 65 and have been eligible for Part B for less than six months, you may still be in your Medigap open enrollment period. If you leave our plan while you are still in your open enrollment period, a Medigap insurer cannot refuse to sell you any policy, you choose, or impose limits based on your health. You might also have a **“guaranteed issue right.”** This means that in certain circumstances, and for a limited period of time, a Medigap insurer must sell you a Medigap policy, even if you have health problems. In general, you do not have a guaranteed issue right if you simply decide to disenroll from Tufts Medicare Preferred HMO Prime. However, for example, you have a guaranteed issue right to buy a Medigap policy if you are in a trial period. You may be in a trial period if, in the past 12 months you: (1) dropped a Medigap policy to join Tufts Medicare Preferred HMO Prime or another Medicare health plan for the first time; or (2) joined Tufts Medicare Preferred HMO Prime or another Medicare health plan when you first became entitled to Medicare at age 65. Under certain circumstances, if you lose your health plan coverage while you are still in a trial period, the trial period can last for an extra 12 months. You may also have a guaranteed issue right if you move out of our service area. SHINE can tell you about other situations where you may have guaranteed issue rights. If you do want to buy a Medigap policy, you have to follow the instructions shown previously for changing from Tufts Medicare Preferred HMO Prime to Original Medicare. (Buying a Medigap policy does not switch you from Tufts Medicare Preferred HMO Prime to Original Medicare. In fact, while you are still enrolled in Tufts Medicare Preferred HMO Prime it is against the law for a Medigap insurance company to sell you a policy. A Medigap sales person or insurance agent cannot cancel your Tufts Medicare Preferred HMO Prime membership and put you in Original Medicare.)

What happens to you if Tufts Health Plan leaves the Medicare program or Tufts Medicare Preferred HMO Prime leaves the area where you live?

If we leave the Medicare program or change our service area so that it no longer includes the area where you live, we will tell you in writing. If this happens, your membership in Tufts Medicare Preferred HMO Prime will end, and you will have to change to another way of getting your Medicare benefits. All of the

benefits and rules described in this booklet will continue until your membership ends. This means that you must continue to get your medical care in the usual way through Tufts Medicare Preferred HMO Prime until your membership ends.

Your choices for how to get your Medicare will always include Original Medicare and joining a Prescription Drug Plan to complement your Original Medicare coverage. Your choices may also include joining another Medicare Advantage Plan, or a Private Fee-for-Service plan, if these plans are available in your area and are accepting new members. Once we have told you in writing that we are leaving the Medicare program or the area where you live, you will have a chance to change to another way of getting your Medicare benefits. If you decide to change from Tufts Medicare Preferred HMO Prime to Original Medicare, you will have the right to buy a Medigap policy regardless of your health. This is called a “guaranteed issue right” and it is explained earlier in this section under the heading, “Do you need to buy a Medigap (Medicare supplement insurance) policy?”

Tufts Health Plan has a contract with the Centers for Medicare & Medicaid Services (CMS), the government agency that runs Medicare. This contract renews each year. At the end of each year, the contract is reviewed, and either Tufts Health Plan or CMS can decide to end it. You will get 90 days advance notice in this situation. It is also possible for our contract to end at some other time during the year, too. In these situations we will try to tell you 90 days in advance, but your advance notice may be as little as 30 or fewer days if CMS must end our contract in the middle of the year.

Whenever a Medicare health plan leaves the Medicare program or stops serving your area, you will be provided a special enrollment period to make choices about how you get Medicare, including choosing a Medicare Prescription Drug Plan and guaranteed issue rights to a Medigap policy.

Under certain conditions Tufts Health Plan can end your membership and make you leave the plan.

Generally, we *cannot* ask you to leave the plan because of your health.

Unless you are a member of a Medicare Advantage Special Needs Plan (SNP) for chronic conditions, we cannot ask you to leave your health plan for any health-related reasons. If you ever feel that you are being encouraged or asked to leave Tufts Medicare Preferred HMO Prime because of your health, you should call 1-800-MEDICARE (1-800-633-4227), which is the national Medicare help line. TTY users should call 1-877-486-2048. You can call 24 hours a day, 7 days a week.

We *can* ask you to leave the plan under certain special conditions.

If any of the following situations occur, we will end your membership in Tufts Medicare Preferred HMO Prime.

- **If you move out of the service area or are away from the service area for more than six months in a row.** If you move permanently out of our geographic service area, or if you are away from our service area for more than six months in a row, you generally cannot remain a member of Tufts Medicare Preferred HMO Prime. In these situations, if you do not leave on your own, we must end your membership (“disenroll” you). An earlier part of this section tells about the choices you have if you leave Tufts Medicare Preferred HMO Prime and explains how to leave. Section 2 gives more information about getting care when you are away from the service area.

- If you do *not* stay continuously enrolled in both Medicare Part A and Medicare Part B
- If you give us information on your enrollment request that you know is false or deliberately misleading, and it affects whether or not you can enroll in Tufts Medicare Preferred HMO Prime.
- If you behave in a way that is disruptive, to the extent that your continued enrollment seriously impairs our ability to arrange or provide medical care for you or for others who are members of Tufts Medicare Preferred HMO Prime. We cannot make you leave Tufts Medicare Preferred HMO Prime for this reason unless we get permission first from the Centers for Medicare & Medicaid Services, the government agency that runs Medicare.
- If you let someone else use your plan membership card to get medical care. If you are disenrolled for this reason, CMS may refer your case to the Inspector General for additional investigation.
- If you do not pay the plan premiums, we will tell you in writing that you have a 90-day grace period during which you can pay the plan premiums before you are required to leave Tufts Medicare Preferred HMO Prime.

You have the right to make a complaint if we ask you to leave Tufts Health Plan HMO Prime

If we ask you to leave Tufts Medicare Preferred HMO Prime, we will tell you our reasons in writing and explain how you can file a complaint against us if you want to.

Section 14 Legal Notices

Notice about governing law

Many different laws apply to this Evidence of Coverage. Some additional provisions may apply to your situation because they are required by law. This can affect your rights and responsibilities even if the laws are not included or explained in this document. The principal law that applies to this document is Title XVIII of the Social Security Act and the regulations created under the Social Security Act by the Centers for Medicare & Medicaid Services, or CMS. In addition, other federal laws may apply and, under certain circumstances, the laws of the State(s) of Massachusetts may apply.

Notice about non-discrimination

When we make decisions about the provision of health care services, we do not discriminate based on a person's race, disability, religion, sex, sexual orientation, health, ethnicity, creed, age, or national origin. All organizations that provide Medicare Advantage Plans, like Tufts Health Plan, must obey federal laws against discrimination, including Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, all other laws that apply to organizations that receive federal funding, and any other laws and rules that apply for any other reason.

Notice about conditional payments

A conditional payment is one that we make if you have other insurance available and another insurance company, such as a liability insurance company, is the liable payer but will not pay the claim within 120 days. (See more information in Section 8). We pay the claim so that you will not have to use your own money to pay the bill. Under Medicare law, we are entitled to recover conditional payments once a settlement is reached.

Notice about the relationship between Tufts Health Plan and providers

Tufts Health Plan arranges health care services. Tufts Health Plan does **not** provide health care services. Tufts Health Plan has contractual agreements with providers practicing in their private offices throughout the service area. These providers are independent. They are not Tufts Health Plan employees, agents or representatives. Providers are not authorized to change this *Evidence of Coverage* or assume or create any obligation for Tufts Health Plan.

Section 15 Definitions of some words used in this booklet

For the terms listed below, this section either gives a definition or directs you to a place in this booklet that explains the term

Appeal – A type of complaint you make when you want us to reconsider and change a decision we have made about what services are covered for you or what we will pay for a service. Sections 11 and 12 explain about appeals, including the process involved in making an appeal.

Benefit period – For both Tufts Medicare Preferred HMO Prime and Original Medicare, a benefit period is used to determine coverage for stays in rehabilitation or long-term care hospitals and skilled nursing facilities. A benefit period *begins* on the first day you go to a Medicare-covered rehabilitation or long-term care hospital or a skilled nursing facility. The benefit period *ends* when you have not been an inpatient at any rehabilitation or long-term care hospital or SNF for 60 days in a row. If you go to a rehabilitation or long-term care hospital (or SNF) after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods you can have. The type of care you actually receive during the stay determines whether you are considered to be an inpatient for SNF stays, but not for rehabilitation or long-term care hospital stays.

You are an inpatient in a SNF only if your care in the SNF meets certain skilled level of care standards. Specifically, in order to have been an inpatient while in a SNF, you must need daily skilled nursing or skilled rehabilitation care, or both. (Section 7 tells what is meant by skilled care.)

Generally, you are an inpatient of a rehabilitation or long-term care hospital if you are receiving inpatient services in a rehabilitation or long-term care hospital (the type of care you actually receive in the rehabilitation or long-term care hospital does not determine whether you are considered to be an inpatient in the rehabilitation or long-term care hospital).

Brand Name Drug – A prescription drug that is manufactured and sold by the pharmaceutical company that originally researched and developed the drug. Brand name drugs have the same active-ingredient formula as the generic version of the drug. However, generic drugs are manufactured and sold by other drug manufacturers and are not available until after the patent on the brand name drug has expired.

Centers for Medicare & Medicaid Services (CMS) – The federal agency that runs the Medicare program. Section 1 tells how you can contact CMS.

Coverage Determination - The plan sponsor has made a coverage determination when it makes a decision about the prescription drug benefits you can receive under the plan, and the amount that you must pay for a drug.

Covered services – The general term we use in this booklet to mean all of the health care services and supplies that are covered by Tufts Medicare Preferred HMO Prime. Covered services are listed in the Benefits Chart in Section 4.

Creditable Coverage – Coverage that is at least as good as the standard Medicare prescription drug coverage.

Customer Relations – A department within Tufts Health Plan responsible for answering your questions about your membership, benefits, grievances and appeals. See Section 1 for information about how to contact Customer Relations

Disenroll or disenrollment – The process of ending your membership in Tufts Medicare Preferred HMO Prime. Disenrollment can be voluntary (your own choice) or involuntary (not your own choice). Section 13 tells about disenrollment.

Durable medical equipment – Equipment needed for medical reasons, which is sturdy enough to be used many times without wearing out. A person normally needs this kind of equipment only when ill or injured. It can be used in the home. Examples of durable medical equipment include wheelchairs, hospital beds, or equipment that supplies a person with oxygen.

Emergency care – Covered services that are 1) furnished by a provider qualified to furnish emergency services; and 2) needed to evaluate or stabilize an emergency medical condition. Section 3 tells about emergency services.

Evidence of coverage and disclosure information – This document along with your enrollment form which explains your covered services, defines our obligations, and explains your rights and responsibilities as a member of Tufts Medicare Preferred HMO Prime.

Exception – A type of coverage determination that, if approved, allows you to obtain a drug that is not on our formulary (a formulary exception), or receive a non-preferred drug at the preferred cost-sharing level (a tiering exception). You may also request an exception if we require you to try another drug before receiving the drug you are requesting, or the plan limits the quantity or dosage of the drug you are requesting (a formulary exception).

Formulary – A list of covered drugs provided by the plan.

Generic Drug – A prescription drug that has the same active-ingredient formula as a brand name drug. Generic drugs usually cost less than brand name drugs and are rated by the Food and Drug Aministration (FDA) to be as safe and effective as brand name drugs.

Grievance – A type of complaint you make about us or one of our plan providers, including a complaint concerning the quality of your care. This type of complaint does not involve payment or coverage disputes. See Section 10 for more information about grievances.

Inpatient Care – Health care that you get when you are admitted to a hospital.

Late Enrollment Penalty – An amount added to your monthly premium for Medicare drug coverage if you don't join a plan when you're first able. You pay this higher amount as long as you have Medicare. There are some exceptions. If you do not have creditable prescription drug coverage, you will have to pay a penalty in addition to your monthly plan premium.

Medically necessary – Services or supplies that: are proper and needed for the diagnosis or treatment of your medical condition; are used for the diagnosis, direct care, and treatment of your medical condition; meet the standards of good medical practice in the local community; and are not mainly for the convenience of you or your doctor.

Medicare – The federal health insurance program for people 65 years of age or older, some people under age 65 with disabilities, and people with End-Stage Renal Disease (generally those with permanent kidney failure who need dialysis or a kidney transplant).

Medicare Advantage Organization – A public or private organization licensed by the State as a risk-bearing entity that is under contract with the Centers for Medicare & Medicaid Services (CMS) to provide covered services. Medicare Advantage Organizations can offer one or more Medicare Advantage Plans. Tufts Health Plan is a Medicare Advantage Organization.

Medicare Advantage Plan – A benefit package offered by a Medicare Advantage Organization that offers a specific set of health benefits at a uniform premium and uniform level of cost-sharing to all people with Medicare who live in the service area covered by the Plan. A Medicare Advantage Organization may offer more than one plan in the same service area. Tufts Medicare Preferred HMO Prime is a Medicare Advantage Plan.

Medicare Managed Care Plan – Means a Medicare Advantage HMO, Medicare Cost Plan, or Medicare Advantage PPO.

Medicare Prescription Drug Coverage – Insurance to help pay for outpatient prescription drugs, vaccines, biologicals, and some supplies not covered by Medicare Part B.

“Medigap” (Medicare supplement insurance) policy – Many people who get their Medicare through Original Medicare buy “Medigap” or Medicare supplement insurance policies to fill “gaps” in Original Medicare coverage.

Member (member of Tufts Medicare Preferred HMO Prime, or “plan member”) – A person with Medicare who is eligible to get covered services, who has enrolled in Tufts Medicare Preferred HMO Prime, and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Services (CMS).

Network Pharmacy – A network pharmacy is a pharmacy where members of our Plan can receive covered prescription drug benefits. We call them “network pharmacies” because they contract with our Plan. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies.

Non-plan provider or non-plan facility – A provider or facility that we have not arranged with to coordinate or provide covered services to members of Tufts Medicare Preferred HMO Prime. Non-plan providers are providers that are not employed, owned, or operated by Tufts Health Plan and are not under contract to deliver covered services to you. As explained in this booklet, most services you get from non-plan providers are not covered by Tufts Health Plan or Original Medicare.

Organization Determination - The MA organization has made an organization determination when it, or one of its providers, makes a decision about MA services or payment that you believe you should receive.

Original Medicare – Some people call it “traditional Medicare” or “fee-for-service” Medicare. Original Medicare is the way most people get their Medicare Part A and Part B health care. It is the national pay-per-visit program that lets you go to any doctor, hospital, or other health care provider who accepts Medicare. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share. Original Medicare has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance) and is available everywhere in the United States.

Out-of-Network Pharmacy – A pharmacy that we have not arranged with to coordinate or provide covered drugs to members of our Plan. As explained in this Evidence of Coverage, most services you get from non-network pharmacies are not covered by our Plan unless certain conditions apply. See Section 6.

Part D – The voluntary Prescription Drug Benefit Program. (For ease of reference, we will refer to the new prescription drug benefit program as Part D.)

Part D Drugs – Any drug that can be covered under a Medicare Prescription Drug Plan. Generally, any drug not specifically excluded under Medicare drug coverage is considered a Part D Drug.

Plan provider – “**Provider**” is the general term we use for doctors, other health care professionals, hospitals, and other health care facilities that are licensed by the state, and when required, certified by Medicare and by the State to provide health care services. We call them “**plan providers**” when they have an agreement with Tufts Medicare Preferred HMO Prime to accept our payment as payment in full, and in some cases to coordinate as well as provide covered services to members of Tufts Medicare Preferred HMO Prime. Tufts Health Plan pays plan providers based on the agreements it has with the providers.

Primary Care Physician (PCP) – A health care professional who is trained to give you basic care. Your PCP is responsible for providing or authorizing covered services while you are a plan member. Section 2 tells more about PCPs.

Preferred Provider Organization Plan – A Preferred Provider Organization plan is an MA plan that has a network of contracted providers that have agreed to treat plan members for a specified payment amount. A PPO plan must cover all plan benefits whether they are received from network or non-network providers. Member cost sharing may be higher when plan benefits are received from non-network providers.

Prior authorization – Approval in advance to get services. Some in-network services are covered only if your doctor or other plan provider gets “prior authorization” from Tufts Health Plan. Covered services that need prior authorization are marked in the Benefits Chart. Prior authorization is not required for out-of-network services. You do not need prior authorization to obtain out-of-network services. However, you may want to check with your plan before obtaining services out-of-network to confirm that the service is covered by your plan and what your cost share responsibility is. If your plan offers Part D drugs, certain drugs may require prior authorization. Check with your plan.

Quality Improvement Organization (QIO) – Groups of practicing doctors and other health care experts who are paid by the federal government to check and improve the care given to Medicare patients. They must review your complaints about the quality of care given by doctors in inpatient hospitals, hospital outpatient departments, hospital emergency rooms, skilled nursing facilities, home health agencies, Private fee-for-service plans and ambulatory surgical centers. See Section 1 for information about how to contact MassPRO in your state and Section 10 for information about making complaints to MassPRO.

Referral – Your PCP’s approval for you to see a certain plan specialist or to receive certain covered services from plan providers.

Rehabilitation services – These services include physical therapy, cardiac rehabilitation, speech and language therapy, and occupational therapy that are provided under the direction of a plan provider. See Section 7 for more information.

Service area – Section 2 tells about Tufts Medicare Preferred HMO Prime’s service area. “Service area” is the geographic area approved by the Centers for Medicare & Medicaid Services (CMS) within which an eligible individual may enroll in a particular plan offered by a Medicare Health Plan.

Urgently needed care – Section 3 explains about urgently needed services. These are different from emergency services.

Questions?

Tufts Health Plan Medicare Preferred Customer Relations

For help or information please call
Customer Relations. Calls to these
numbers are free:

1-800-701-9000

TDD: 1-800-208-9562

Representatives are available
Monday – Friday,
8:30 a.m. – 5:00 p.m.

For prescription drug related ques-
tions only, call 7 days a week
8:00 a.m. – 8:00 p.m.

Or log onto our website at
www.tuftshealthplan.com



705 Mt. Auburn Street
Watertown, MA 02472

www.tuftshealthplan.com